



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

March 6, 2003

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #73

The following acronyms are used in this transmittal:

- ABD - Aged, Blind, and Disabled
- BCCPTA - Breast and Cervical Cancer Prevention and Treatment Act
- F&C - Families and Children
- FAMIS - Family Access to Medical Insurance Security Plan
- FPL - Federal Poverty Limit
- INS - Immigration and Naturalization Service
- MI - Medically Indigent
- MMIS - Medicaid Management Information Systems
- MN - Medically Needy
- QI - Qualified Individuals
- SAVE - Systematic Alien Verification for Entitlements
- SS - Social Security
- SSA - Social Security Administration

This transmittal contains the new MI and FAMIS income limits. The new income limits were effective February 7, 2003, for all F&C MI, ABD MI without SS, and FAMIS eligibility determinations. The new income limits are effective April 1, 2003, for all ABD MI with SS eligibility determinations. All other policy clarifications and updates contained in this transmittal are effective for all eligibility determinations completed on or after April 1, 2003.

This transmittal completes the transition from the "old" Medicaid Manual to the Medicaid Manual - Volume XIII; Therefore, the "old" Medicaid Manual is now obsolete. Part II, Chapter C Asset Transfer, has been eliminated. Subchapter M1450 currently contains all applicable policy regarding transfer of assets. Part II, Chapter F Spenddown, has been eliminated. References to Part II, Chapter F have been eliminated from the manual, and the Regional Consultant must be contacted to obtain the policy and procedures for Medicaid spenddowns established prior to July 1, 1999. A new chapter, M18 Medical Services, is included in this transmittal and replaces Part III, Chapter D.

The "old" manual will be retained by the Regional Consultants for reference purposes and should be destroyed by all other users. The Medicaid Manual will soon be available on the local agency

intranet. Instructions on accessing the on-line manual and policy concerning the dissemination of paper copies of the manual will be issued via a broadcast within the next several weeks.

Subchapter M0220 is revised to expand the definition of individuals who acquire citizenship to include children who have been adopted by U.S. citizen parents. Verification procedures have been clarified regarding the use of the SAVE system for aliens who present expired Alien Registration Receipt Cards (Form I-551). The requirement to report illegal aliens who apply for Medicaid to the INS has been eliminated. Victims of a severe form of trafficking, a group of qualified aliens who entered the U.S. on or after 8-22-96, has been added to the list of aliens receiving full-benefit status. As this group does not have immigrant status, verification of alien status for this group is by certification letter and telephonically rather than by the SAVE system. Refer to Broadcast 1461 for more information on this group. Appendix 6 in M0220 adds procedures for calculating 40 hours of qualifying quarters of coverage for lawful permanent residents after five (5) years have passed from the date of entry into the U.S.

Subchapter M0320 has been revised to eliminate the QI-2 covered group. Funding for this federally-established group expired on December 31, 2002. Future transmittals will eliminate any existing references to the QI-2 covered group.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Virginia DSS, Volume XIII Table of Contents page iii	Virginia DSS, Volume XIII Table of Contents page iii	Page iii of the Table of Contents is revised to add chapter M18.
Subchapter M0130 pages 3, 4	Subchapter M0130 pages 3, 4	Page 3 is a reprint. On page 4, clarified application processing policy.
Subchapter M0210 pages 1-3	Subchapter M0210 pages 1-3	On pages 1 and 3, deleted the references to Part II, Chapter C. Page 2 is a reprint. On page 3, revised pursuit of support policy.
Subchapter M0220 Table of Contents pages 1-8 pages 14a-14d pages 19-25 Appendices 1-4, pages 26-43	Subchapter M0220 Table of Contents pages 1-8 pages 14a-14d pages 19-25 Appendix 1 Appendix 2 Appendix 2a Appendix 3 Appendix 4 Appendix 5 Appendix 6	The Table of Contents is revised to add Appendices 2a, 5, and 6. Page 1 is a reprint. On pages 2 and 3, added procedures for determining citizenship of adopted children. On page 4, revised the procedures for verifying alien status. Page 5 is a runaway. On page 6, added procedures for using the Form G-845 Supplement. On page 7,

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Significant Changes

revised the list of qualified aliens to include victims of a severe form of trafficking. Page 8 is a reprint. On page 14a, clarified the date of entry for an alien with an adjusted status. On page 14b, added procedures for victims of a severe form of trafficking and a reference to Appendix 6. On page 14c, added procedures for victims of a severe form of trafficking. Page 14d is a run-over page. Page 19 is a reprint. On page 20, corrected the manual format. On page 21, deleted the reference to pursuit of spousal support and revised the reference for asset transfer. On page 22, added the form number for the Emergency Medical Certification form. On page 22a, added the new Alien Chart Codes for victims of a severe form of trafficking. On page 23, added reference to subchapter M0220, Appendix 4. On page 24, revised the Alien Chart codes for emergency services aliens and visitor, non-immigrant aliens. Page 25 is a reprint. In Appendices 1 and 2, revised the page numbers. Appendix 2a, the Form G-845 Supplement, is added. In Appendix 3, revised the page numbers and added victims of a severe form of trafficking. In Appendix 4, revised the page numbers.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0240 pages 1, 2	Subchapter M0240 page 1, 2	Appendix 5, Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking, is added. Appendix 6, SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents, is added. On page 1, revised the reference for the definition of a child. Page 2 is a reprint.
Subchapter M0250 pages 5, 6	Subchapter M0250 pages 5, 6	On page 5, corrected the manual format. Page 6 is a reprint.
Subchapter M0320 Table of Contents pages 1-6 pages 15, 16 pages 21-22 pages 23-26 pages 29-32 pages 35, 36 pages 39-42f pages 45-48 pages 53-64 pages 67-70 Appendix 1	Subchapter M0320 Table of Contents pages 1-6 pages 15, 16 pages 21-22 pages 23-26 pages 29-32 pages 35, 36 pages 39-42f pages 45-48 pages 53-64 pages 67-70	In the Table of Contents, revised QI covered group and deleted Appendix 1. On page 1, revised the reference to the QI covered group. On pages 2-4, deleted the references to AFDC. On page 5, revised the reference for pursuit of support. Page 6 is a reprint. On page 15, deleted the reference to Part II, chapter C. Page 16 is a reprint. On page 21, deleted the reference to Part II, chapter C. Page 22 is a reprint. On page 23, revised the reference to the QI covered group and deleted the reference to Part II, chapter C. Page 24 is a reprint. On page 25, revised the policy on evaluating ineligible SSI recipients for eligibility in

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Significant Changes

other covered groups and deleted the reference to Part II, chapter C. On pages 26 and 29, deleted the references to Part II, chapter C. Pages 30 and 31 are reprints. On pages 32 and 35, deleted the references to Part II, chapter C. Page 36 is a reprint. On page 39, deleted the reference to Part II, chapter C. Pages 40 and 41 are reprints. On page 42-42d, deleted the policy on QI-2 and changed the name of the QI-1 covered group to Qualified Individuals. On page 42b, also deleted the reference to Part II, chapter C. Page 42e is a run-over page. On page 42f and 45, deleted the references to Part II, chapter C. Pages 46 and 47 are reprints. On page 48, revised the reference to Medicaid covered services. On page 53, deleted the reference to Part II, chapter C. Page 54 is a reprint. On page 55, revised the reference to the MI Child covered groups. On page 56, revised the reference to AFDC income limits. On page 57, deleted the reference to Part II, chapter C. Page 58 is a reprint. On page 59, deleted the reference to Part II, chapter C. Page 60 is a reprint. On page 61, deleted the reference to Part II, chapter C. Pages 62 and 63 are reprints. On pages 64 and 67, deleted the references to Part II, chapter C. On page 67, also

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0330 Table of Contents pages 3-12 pages 15-18 pages 21, 22 pages 25-27	Subchapter M0330 Table of Contents pages 3-12 pages 15-18 pages 21, 22 pages 25-27	<p>clarified that payment for hospice services is for Medicaid eligible individuals. Pages 68 and 69 are reprints. On page 70, revised the reference to the BCCPTA Medicaid Application/Redetermination form.</p> <p>The Table of Contents contains a page number revision. On page 3, clarified the policy on asset transfer and deleted the reference to Part II, chapter C. On page 4, revised the references for spenddown policy. Page 5 is a reprint. On page 6, deleted the references to Part II, chapter C. On page 7, revised the reference to spenddown policy. On pages 8 and 9, deleted the references to Part II, chapter C. On page 9, also revised the reference to spenddown policy. Page 10 is a reprint. On page 11, revised the reference to pursuit of support. Pages 12 and 15 are reprints. On page 16, deleted the reference to Part II, chapter C and revised the reference to pursuit of support. On page 17, deleted the reference to Part II, chapter C. On page 18, updated the example. On page 21, revised the reference to pursuit of support and the references to the MI child covered groups. On page 22,</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0710 Appendix 6, pages 1, 2 Appendix 7, page 1	Subchapter M0710 Appendix 6, pages 1, 2 Appendix 7, page 1	deleted the reference to Part II, chapter C and revised the reference to spenddown policy. On page 25, revised the references to the MI child covered groups. Page 26 is a reprint. On page 27, deleted the reference to Part II, chapter C. Appendix 6 and Appendix 7 are revised to include the increased F&C MI income limits based on the 2/7/03 FPL.
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	Page 1 is a reprint. Page 2 is revised to include the increased income limits based on the 2/7/03 FPL.
Subchapter M1310 page 1, 2	Subchapter M1310 page 1, 2	On page 1, added an instruction to contact the Regional Consultants. On page 2, clarified a break in spenddown eligibility.
Subchapter 1340 pages 3-6	Subchapter 1340 pages 3-6	On page 3, revised the reference to Medicaid covered services. Page 4 is a reprint. On page 5, revised the reference to Medicaid covered services. Page 6 is a reprint.
Subchapter 1410 pages 7, 8 pages 13-16	Subchapter 1410 pages 7, 8 pages 13-16	Page 7 is a reprint. On page 8, revised the reference to Medicaid application requirements. Page 13 is a reprint. On page 14, revised the reference to the sample letter requesting an applicant's signature.

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Significant Changes

Subchapter 1460
pages 11, 12

Subchapter 1460
pages 11, 12

Page 15 is a reprint. On page 16, revised the reference to Medicaid application requirements.

On page 11, deleted the reference to the QI-2 covered group. On page 12, revised the reference to the MI child covered groups.

Subchapter 1510
pages 5, 6

Subchapter 1510
pages 5, 6

On page 5, revised the references to spenddown policy. Page 6 is a reprint.

None

Chapter M18
Title page
Table of contents
pages 1-17
Appendix 1

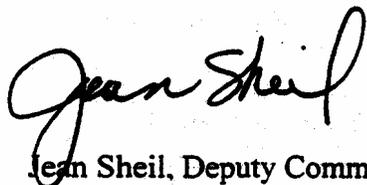
Chapter M18 Medical Services is added.

Chapter M21
Appendix 1
Appendix 2, pages 1, 2

Chapter M21
Appendix 1
Appendix 2, pages 1, 2

Appendix 1 is revised to include the increased FAMIS income limits based on the 2/7/03 FPL. In Appendix 2, updated Local Choice Agencies list.

Please retain this transmittal letter in the back of Volume XIII.



Jean Sheil, Deputy Commissioner

Attachments

M15 ENTITLEMENT POLICY & PROCEDURES

MEDICAID ENTITLEMENT.....M1510
MEDICAID ELIGIBILITY REVIEWM1520
DMHMRSAS FACILITIES.....M1550

M16 APPEALS PROCESS

M17 MEDICAID FRAUD AND RECOVERY

M18 MEDICAL SERVICES

**M21 TITLE XXI: FAMILY ACCESS TO MEDICAL SECURITY
INSURANCE PLAN (FAMIS)**

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 (see M1510, Appendix 1).

Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which 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 or application for the number, and date of birth.

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.

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.

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:

- U.S. citizenship, if born in the U.S.,
- Virginia state residency,
- application for other benefits,
- institutional status,
- age for children under age 19,
- Social Security number (see section D below), and
- health insurance information (see sections E and F below).

The following information must be verified:

- age of applicants age 65 and older,
- disability and blindness,
- pregnancy, and

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 possible covered groups and categories, and the applicant/recipient 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. Citizenship/alien status (M0220).
- b. Virginia residency (M0230).
- c. Social security number provision/application requirements (M0240).
- d. Assignment of rights to medical benefits *and pursuit of support from the absent parent* requirements (M0250).
- e. Application for other benefits (M0270).
- f. Institutional status requirements (M0280).
- g. Application to the Health Insurance Premium Payment Program (HIPP) (M0290).
- h. Covered group requirements (M03).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

- a. Asset transfer (*subchapter M1450 for all individuals*).
- 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).

EXAMPLE #1: On July 5, 1996, Mr. H applies for Medicaid. He is in a nursing facility in Virginia. When evaluating his application, the worker finds that he:

- 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 Property** An individual who transferred property:
- 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 or 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 Social Security Number** Any individual, except a child under age 1 born to a Medicaid-eligible mother or an illegal alien, who does not apply for a Social Security account number (SSN) or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for Medicaid.

M0210.200 CLASSIFICATION OF CASES

- A. Introduction** An individual who meets the nonfinancial eligibility requirements must meet a classification and covered group in order to be eligible for Medicaid. Medicaid eligible individuals fall into four classifications:
1. Categorically Needy
 2. Categorically Needy Non-money Payment
 3. Medically Needy
 4. Medically Indigent

Within each classification are several covered groups of eligible individuals. See chapter M03 for the covered groups' policy and procedures.

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M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

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Full Benefit Aliens.....	M0220.300.....	7
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<i>Document Verification Request (Form G-845)</i>	<i>Appendix 2.....</i>	<i>1</i>
<i>Document Verification Request Supplement</i>		
<i>(Form G-845 Supplement)</i>	<i>Appendix 2a.....</i>	<i>1</i>
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<i>Emergency Medical Certification (Form 032-03-628)</i>	<i>Appendix 4.....</i>	<i>1</i>
<i>Sample Letters of Certification/Eligibility for Victims of a</i>		
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C. Procedures

The policy and procedures for determining whether an individual is a citizen or a “full benefit” or an “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

M0220.100 CITIZENSHIP AND NATURALIZATION**A. Introduction**

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

B. Procedures**1. Individual Born in the U.S.**

An individual born in the United States, any of its territories (Guam, Puerto Rico, U.S. Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is presumed to be a citizen unless there is reason to question. If questionable, citizenship is verified by the individual's birth certificate or U.S. Passport. If such documents are not available, a signed statement of another person attesting to the individual's place of birth if in the U.S. is acceptable verification.

2. Individual Born Outside the U.S.**a. Individual Born of or Adopted by U.S. Citizen Parents**

A child or individual born outside the United States of 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. Individuals who have acquired automatic citizenship do not need to apply for citizenship.*

b. Individual Born of Naturalized Parents

A child born outside the United States of 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.

3. Verification

For an individual born outside the U.S. *other than an adopted child*, citizenship is verified by a certificate of derivative citizenship, passport, naturalization papers, or document issued by a U.S. Embassy or Consulate attesting that the person is a U.S. citizen born abroad, such as Form FS-240, "Report of Birth Abroad of a Citizen of the U.S." or Form I-97 "Consulate Report of Birth or Certification of Birth." If such documents are not available, citizenship must be verified through the nearest U.S. Immigration and Naturalization Service (*INS*). Locations and telephone numbers are:

Norfolk Commerce Park
5280 Henneman Drive
Norfolk, Virginia 23513
Telephone - (757) 858-6183

4420 N. Fairfax Drive
Arlington, Virginia 22203
Telephone - (703) 235-4026

For a legally adopted child born outside the U.S., citizenship is verified by the adoption papers and verification of lawful permanent resident status at the time of adoption.

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.

M0220.201 IMMIGRATION STATUS VERIFICATION**A. Verification Procedures**

An alien's immigration status is verified by the original version of an official document issued by the Immigration and Naturalization Services (*INS*) and a comparison with the Systematic Alien Verification for Entitlements (*SAVE*) system. The EW must see the original document, not a copy. Photocopies of documents or just the submission of an alien number are NOT sufficient verification.

If the alien

- has an alien number but no INS document, or
- has no alien number and no INS 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 an Alien Registration Receipt 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 an Alien Registration Receipt Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).

Form I-151, Form AR-3 and AR-3a are earlier versions of the Alien Registration Receipt Card. An alien with one of the older cards who does not have an I-551 should be referred to INS to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-755-0777.

C. Letters that Verify Status

The INS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with INS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For INS letters, contact the local INS office for assistance in identifying the alien's status (see Appendix 1 of this subchapter). For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 5 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local INS Office Documents

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

E. Expired or Absent Documentation

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

If the applicant provides an alien registration number with supporting verification of his or her identity, use the SAVE procedures in M0220.202 below to verify immigration status. If an applicant presents an expired I-551, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551, follow procedures for initiating a secondary verification.

If the alien does not provide verification of his/her 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 Immigration and Naturalization Service (INS).

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 INS 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. The alien registration number begins with an "A" and should be displayed on the alien's INS document(s).

SAVE is accessible either by the local agency directly or through regional office contact. A primary verification document must be **initiated prior to case approval**.

Information obtained through SAVE should be compared with the original INS 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.

The primary verification document must be stapled to the original "Declaration of Citizenship or Alien Status" and 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 INS document, or the alien has no alien number and no INS 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 INS 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 will complete the top portion of a Document Verification Request (*Form G-845*). *Appendix 2 of this subchapter contains a copy of the form.*

B. Document Verification Request (*Form G-845*)

If the alien has filed an INS 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 INS contemplates enforcing departure is not sufficient basis for determining the alien's status. In such situations, verify the alien's status with INS 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. A copy of the G-845 Supplement is in Appendix 2a of this subchapter.*

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. A photocopy of the completed *G-845* form must be stapled to the original "Declaration of Citizenship or Alien Status" as evidence that the form has been forwarded to INS. Refer to Appendix 1 for the INS mailing address appropriate to your local DSS agency.

C. Agency Action

While awaiting the secondary verification from INS, do not take any negative action on the individual's eligibility **on the basis of alien status**. Upon receipt of the *G-845*, compare the information with the case record. Staple the *G-845* to the original "Declaration of Citizenship or Alien Status". Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

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 (M0220.301);
- 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, *or victim of a severe form of trafficking* 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 “grandfathered” alien 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-

- 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., 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 the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). These 4 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.*

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 **lawful permanent resident who has at least 40 qualifying quarters of work.**

1. **Lawful Permanent Residents (LPRs)**

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.

AFTER 5 years have passed from the date of entry into the U.S., Lawful Permanent Residents who have at least 40 qualifying quarters of work are “full benefit” aliens. Lawful Permanent Residents 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 6 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, Food Stamps and Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement.

- C. AFTER 7 Years of Residence in U.S.** After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, *or victim of a severe form of trafficking* (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.
- D. Services Available To Eligibles**
- 1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking** A qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, *or victim of a severe form of trafficking* (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, *or victim of a severe form of trafficking* 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., a lawful permanent resident alien 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.
- E. 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 GRANDFATHERED ALIENS

- A. Grandfathered Aliens** Certain groups of aliens who are not eligible for full Medicaid benefits because of their alien status may remain eligible or become eligible for full benefits based on the alien status requirements in effect prior to July 1, 1997. These are the “grandfathered” groups of aliens. The two grandfathered groups of aliens are:

1. Aliens in Long-term Care Receiving Medicaid On 6-30-97

All aliens receiving Medicaid and residing in long-term care (LTC) medical facilities or receiving Medicaid home and community-based waiver services on June 30, 1997, who are eligible for full Medicaid benefits on June 30, 1997, continue to be eligible for full benefits after June 30, 1997. This does NOT include aliens who were receiving Medicaid erroneously on 6-30-97.

This means that the alien had to be correctly determined eligible and actually enrolled on the MMIS on or before June 30, 1997. It does NOT include aliens whose applications were acted upon after June 30, 1997.

To be eligible for Medicaid, these aliens must continue to meet all other Medicaid eligibility requirements, including the requirement of residing in an LTC medical facility or receiving Medicaid waiver services. If the alien is discharged from LTC, he/she loses his/her status as a “grandfathered” alien forever. Even if the alien is re-admitted to LTC facility or waiver services, he is not in the “grandfathered” alien group because he lost that status when he was discharged.

Discharge from a nursing facility to a hospital is NOT “discharge from LTC” when the patient is expected to return to the LTC facility, to another LTC facility or to Medicaid CBC waiver services when the hospital stay ends.

2. Aliens Under Age 19

Aliens who are under age 19 years and who would be eligible for full Medicaid benefits if the alien requirements prior to July 1, 1997, were still in effect, are eligible for full benefits. The alien status requirements that were in effect prior to July 1, 1997, are in section B. below.

B. Alien Status Requirements in Effect Prior to 7-1-97 (For Aliens Under Age 19)

Prior to 7-1-97, aliens who had an immigration status as identified below were eligible for full Medicaid benefits if they met all other Medicaid eligibility requirements:

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

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.

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.

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 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/her visa expires,” then the alien has stated his/her intent to reside in Virginia permanently or indefinitely and can meet the state residence eligibility requirement for Medicaid.

2. SSN

the social security number provision/application requirements (M0240);

NOTE: An illegal alien does not have to apply for or provide an SSN.

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. **HIPP** the application to the Health Insurance Premium Payment (HIPP) Program (M0290);
 7. **Covered Group** the covered group requirements (chapter M03);
 8. **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**
- An additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens), is the receipt of an emergency service as certified by DMAS. The worker must obtain a signed Authorization for Release of Information Form from the applicant and request evidence of emergency treatment from the hospital and/or treating physician.
- If the hospital or treating physician wants to know what information is needed, refer the hospital's staff or physician (or physician's staff) to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."
1. **Send To DMAS** The worker must 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. Use the Emergency Medical Certification, *form #032-03-628 (see Appendix 4 of this subchapter)* as a cover letter.

If the applicant is determined not eligible for Medicaid for a reason other than alien status, prior to receipt of the medical determination, notify DMAS to stop work on the case.

- 2. Do Not Take Approval Action Until Form Is Received From DMAS**

Do not take action to approve or enroll an emergency services alien until you receive the Emergency Medical Certification form back from DMAS. The form states whether the service was an emergency and the dates the alien is entitled to Medicaid. You cannot determine the alien's coverage begin or end date without the signed Emergency Medical Certification form from DMAS.
- 3. Separate Certification Form Required**

Each emergency service or treatment received during an eligibility period requires a new, separate certification from the DMAS Division of Program Operations.

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

2. **CI** In this field, Citizenship code, enter the MMIS citizenship code that applies to the alien. Next to the MMIS code is the corresponding Alien Code from the Alien Code Chart in Appendix 3 to this subchapter. Eligible alien codes are:
 - R = refugee (Alien Chart codes F1, F2, G1, G2).
 - 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 = grandfathered aliens only (Alien Chart codes X1, X2, X3, 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. **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 date the alien's Medicaid entitlement begins.
6. **Covered Dates End** Enter data in this field only if eligibility Type is Type 4 (closed period of eligibility in the past). Enter the date the alien's Medicaid entitlement ended.
7. **PD** In this field, Program Designation, enter the code applicable to the alien's covered group.
8. **Type** In this field, enter the appropriate eligibility type 1 (ongoing), 2 (retroactive), 3 (spenddown) or 4 (closed period).

Do NOT use eligibility type 5.

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*.
- Pregnancy-related labor and/or delivery services are emergency medical services for this section's purposes and are covered for emergency services aliens. DMAS determines whether the services were emergency services and determines the period of coverage.
- B. Entitlement-- Eligibility Period** If the applicant is found eligible, eligibility exists only for the period of coverage certified by the DMAS medical staff on the Emergency Services Certification form. The eligibility determination is valid for 6 months including the application month. However, the alien is enrolled on the MMIS only for the period of coverage stated on the Emergency Medical Certification form, # 032-03-628 (*see Appendix 4 of this subchapter*).
- Once an eligibility period is established, additional requests for coverage of emergency services within that period will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification from

the DMAS Division of Program Operations and requires 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 he/she receives an emergency service and wants Medicaid coverage for that service.

C. Enrollment Procedures

Once an emergency services alien is found eligible, he must be enrolled on the Medicaid computer using the following data:

1. Cty

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

2. CI

In this field, Citizenship 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*)

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

The Alien Codes Chart is found in Appendix 3 to this subchapter.

NOTE: 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) certified by DMAS.

6. Covered Dates End

In this field, coverage end date, enter the date the alien's emergency service(s) certified by DMAS ends.

7. PD

In this field, Program Designation, enter the code applicable to the alien's covered group.

8. Type

In this field, **enter Eligibility type "5"**. No other eligibility type is allowed.

D. Notices

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

Appendix 1: IMMIGRATION AND NATURALIZATION SERVICE (INS) OFFICES

1. Agencies corresponding with INS, 4420 North Fairfax Drive, Arlington, VA 22203 (phone: 703-235-4026). These agencies use this INS address to reorder G-845 forms.

Albemarle	Fauquier	Page
Alexandria	Floyd	Patrick
Alleghany	Fluvanna	Pittsylvania
Amherst	Franklin County	Prince William
Appomattox	Frederick	Pulaski
Arlington	Galax	Radford
Bath	Giles	Rappahannock
Bedford	Grayson	Roanoke City
Bland	Greene	Roanoke County
Botetourt	Halifax	Rockbridge
Bristol	Harrisonburg	Rockingham
Buchanan	Henry	Russell
Buckingham	Highland	Scott
Campbell	King George	Shenandoah
Carroll	Lee	Smyth
Charlotte	Loudoun	Stafford
Charlottesville	Lynchburg	Staunton
Chesterfield	Madison	Tazewell
Clarke	Manassas	Warren
Craig	Manassas Park	Washington
Culpeper	Martinsville	Waynesboro
Cumberland	Montgomery	Winchester
Danville	Nelson	Wise
Dickenson	Northumberland	Wythe
Fairfax	Norton	
	Orange	

2. Agencies corresponding with INS, Norfolk Commerce Park, 5280 Henneman Drive, Norfolk, VA 23513 (phone: 757-858-6183). These agencies use this INS address to reorder G-845 forms.

Accomack	Hopewell	Petersburg
Amelia	Isle of Wight	Portsmouth
Brunswick	James City	Powhatan
Caroline	King and Queen	Prince Edward
Charles City	King William	Prince George
Chesapeake	Lancaster	Richmond City
Dinwiddie	Louisa	Richmond County
Essex	Lunenburg	Southampton
Franklin City	Mathews	Spotsylvania
Fredericksburg	Mecklenburg	Suffolk
Gloucester	Middlesex	Surry
Goochland	New Kent	Sussex
Greensville	Newport News	Virginia Beach
Hampton	Norfolk	Westmoreland
Hanover	Northampton	Williamsburg
Henrico	Nottoway	York

U.S. Department of Justice
Immigration and Natural Service

SAVE

OMB 1115-0122
Document Verification Request

Section A – to be completed by the submitting agency.

To: Immigration and Naturalization Service

6. Verification Number

7. Photocopy of Document Attached.
(If printed on both sides, attach a copy of the front and of the back.)
 Other Information Attached *(Specify documents).*

From: Typed or Stamped Name and Address of Submitting Agency

Attn: Status Verifier
(INS may use above address with a #20 window envelope.)

1. Alien Registration or I-94 Number

2. Applicant's Name *(Last, First, Middle)*

3. Nationality

4. Date of Birth *(Month/Day/Year)*

5. Social Security Number

8. <i>(Benefit)</i>	<i>(Your Case Number)</i>
<input type="checkbox"/> AFDC	
<input type="checkbox"/> Education Grant/Loans/Workstudy	
<input type="checkbox"/> Food Stamp	
<input type="checkbox"/> Housing Assistance	
<input type="checkbox"/> Medicaid/Medical Assistance	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Employment Authorization	
<input type="checkbox"/> Other <i>(specify)</i>	

9. Name of Submitting Official

10. Title of Submitting Official

11. Date

12. Telephone Number

Section B – to be completed by INS

INS RESPONSE: From the documents or information submitted and/or a review of our records we find that:

- 1. This document appears valid and relates to a **Lawful Permanent Resident alien** of the United States.
- 2. This document appears valid and relates to a **Conditional Resident alien** of the United States.
- 3. This document appears valid and relates to an alien **authorized employment** as indicated below:
 - a. Full-Time
 - b. Part-Time
 - c. No Expiration (Indefinite)
 - d. Expires on _____
(specify Month/Day/Year, below)
- 4. This document appears valid and relates to an alien who has an application pending for _____
(specify Month/Day/Year, below)
- 5. This document relates to an alien having been **granted asylum/refugee** status in the United States.
- 6. This document appears valid and relates to an alien **paroled** into the United States pursuant to Section 212 of the I&N Act.
- 7. This document appears valid and relates to an alien who is a **Cuban/Haitian entrant**.
- 8. This document appears valid and relates to an alien who is a **conditional entrant**.
- 9. This document appears valid and relates to an alien who is a **nonimmigrant**.
(specify type or class below)
- 10. This document appears valid and relates to an alien **not authorized employment** in the United States.
- 11. Continue to process as legal alien. INS is searching indices for further information.
- 12. This document is **not valid** because it appears to be *(check all that apply)*:
 - a. Expired
 - b. Altered
 - c. Counterfeit

INS Stamp

Comments

13. No determination can be made from the information submitted. Please obtain a copy of the **original** alien registration documentation and resubmit.
14. No determination can be made without seeing **both** sides of the document submitted (*please resubmit request*).
15. Copy of document is not readable (*please resubmit request*):

“PRUCOL”

For Purposes of Determining If Alien Is Permanently Residing Under Color of Law Only!

16. INS actively pursues the expulsion of an alien in this class/category.
17. INS **is not** actively pursuing the expulsion of an alien in this class/category, at this time.
18. Other

Instructions

- **Submit copies of both *front and back* of alien’s original documentation.**
- **Make certain a *complete return address* has been entered in the “From” portion of the form.**
- The Alien Registration Number (“A” Number) is the letter “A” followed by a series of (7) or (8) digits. Also in this block may be recorded the number found on Form I-94. (Check the front and back of the I-94 document, and if the “A” Number appears, record that number when requesting information instead of the longer admission number as the “A” Number refers to the most integral record available.)
- If Form G-845 is submitted without copies of applicant’s original documentation, it will be returned to the submitting agency without any action taken.
- Address this verification to the local office of the Immigration and Naturalization Service.

Appendix 2: Document Verification Request Form (G-845)

The Document Verification Request (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.

1. **Alien Registration Number or I-94 Number** Enter the Alien Registration Number as the letter "A" followed by a series of seven or eight digits. Include also the Admission Number if available. The Admission Number is found on Form I-94 and in the Alternate ID field located on the primary SAVE verification (automated process). The Admission Number may assist in the various searches made during secondary verification.
2. **Applicant's Name** Enter last, first, and middle names of the applicant. If documentation indicates more than one variation of the name, enter all versions.
3. **Nationality** Enter the foreign nation or country to which the applicant owes legal allegiance. This is normally, but not always, the country of birth.
4. **Date of Birth** Enter the birth date using the format MM/DD/YY. If the complete date of birth is not known, give available information.
5. **Social Security Number** Enter the alien's nine-digit Social Security Number, if known. Copy the number directly from the alien's Social Security card whenever possible.
6. **Verification Number** Enter the Verification Number assigned on the primary verification document, if applicable.
7. **Photocopy of Document Attached/ Other Information Attached** Indicate that INS documentation is attached by checking the top box. Use the bottom box if other information has been included in support or in lieu of INS documents.
8. **Benefits Your Case Number** Mark the blocks showing the entitlement benefit program(s) for which this alien has applied. Show applicable case numbers or indicate with "pending," if a case number has not yet been assigned.
9. **Name and Address of Submitting Agency** The submitting individual must provide his name, title, telephone number, and the current date. The name and address of the requesting agency should be typed or stamped in the block labeled "From." Copies of Form G-845 ordered from INS will include the address of the File Control Office responsible for processing the form.

U.S. Department of Justice
Immigration and Naturalization Service

Document Verification Request Supplement

TO BE COMPLETED BY THE SUBMITTING AGENCY

To: Immigration and Naturalization Service Date _____

Applicant's Name (Last, First, Middle) _____

Social Security Number _____

Alien Registration Number or I-94 Number _____

FROM: Typed or Stamped Name and Address of Submitting Agency Telephone(____) _____

Complete the following items: #1 #2 #3 #4 #5 #6 #7
For SSA Use Only: Show 8/22/96 status in #1. Alleged 8/22/96 status _____

TO BE COMPLETED BY INS

1. IMMIGRATION STATUS (check all that apply):
From the document or information submitted and/or a review we find that the person identified is a/an:
 - a. Lawful Permanent Resident alien of the United States.
(Complete b, c, d, g, h, or I if alien adjusted to LPR status from one of those statuses in the past 7 years.)
 - b. Refugee admitted to the United States under Section 207 of the INA. (Complete Item 2 below.)
 - c. Asylee under Section 208 of the INA. (Complete Item 3 below.)
 - d. Alien whose deportation has been withheld under sections 243(b) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under section 241(b)(3).
 - e. Alien paroled into the United States under Section 212(d) (5) of the INA for a period of at least 1 year.
(compare Items 3 and 4 below.)
 - f. Conditional Entrant pursuant to Section 203(a)(7) of the INA in effect prior to April 1, 1980.
 - g. American Indian born in Canada to whom the provisions of Section 289 of the INA apply.
 - h. Cuban/Haitian Entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980.
(Compare Item 3 below)
 - i. Amerasian immigrant, pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1988. (Complete Item 2 below.)
 - j. Other (indicate status): _____
2. Date Alien entered the United States _____
3. Date status was granted: _____
4. Date status expires: _____
5. CITIZEN STATUS:
This document appears valid and relates to a United States citizen.
6. SPECIAL BENEFIT PROVISIONS FOR CERTAIN VICITMS OF ABUSE:
 - a. This alien obtained Lawful Permanent (or Conditional) Resident Status as the spouse, child, or widow(er) of a U.S. citizen.
 - b. This alien obtained a Lawful Permanent (or Conditional) Resident Status as the spouse, child, or unmarried son or daughter of a lawful permanent resident alien.
 - c. This alien did not obtain status as described in (a) or (b).

TO BE COMPLETED BY INS

7. AFFIDAVIT OF SUPPORT:

- a. This alien was sponsored on Form I-864. Affidavit of Support under Section 213A of the INA.
Service receipt date _____ (Complete Item 3 on page 1.)
- b. This alien was not sponsored on Form I-864.

Name of Sponsor	Name of Joint Sponsor(s) (if any)
Sponsor's Social Security Number	Joint Sponsor's Social Security Number
____-____-____	____-____-____
Sponsor's Address	Joint Sponsor Address
_____	_____
_____	_____
_____	_____
_____	_____
	See reverse for information on additional joint sponsor(s).

INS Stamp

- This supplement may be used in conjunction with Form G-845 to request verification; it cannot be used alone. It reflects information that may be relevant to eligibility for Federal, State, and local public benefits under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193.

Line Item	MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1 st 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
			1 st 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 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 section 501(e) of Refugee Education Assistance Act of 1980, 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	<i>Victims of a Severe Form of Trafficking pursuant to the Trafficking Victims Protection Act of 2000, P.L. 106-386 [ORR Certification/eligibility Letter]</i>	<i>N/A</i> J1	<i>Full Benefit</i> J2	<i>Emergency Only</i> J3

	UNQUALIFIED ALIEN GROUPS	Arrived Before 8-22-96	Arrived On or After 8-22-96	
<i>K</i>	Aliens residing in the US pursuant to an indefinite stay of deception [I-94; Immigration Letter]	Emergency Only <i>K1</i>	Emergency Only <i>K2</i>	Emergency Only <i>K3</i>
<i>L</i>	Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter]	Emergency Only <i>L1</i>	Emergency Only <i>L2</i>	Emergency Only <i>L3</i>
<i>M</i>	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 <i>M1</i>	Emergency Only <i>M2</i>	Emergency Only <i>M3</i>
<i>N</i>	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 <i>N1</i>	Emergency Only <i>N2</i>	Emergency Only <i>N3</i>
<i>O</i>	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 <i>O1</i>	Emergency Only <i>O2</i>	Emergency Only <i>O3</i>
<i>P</i>	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 <i>P1</i>	Emergency Only <i>P2</i>	Emergency Only <i>P3</i>
<i>Q</i>	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 <i>Q1</i>	Emergency Only <i>Q2</i>	Emergency Only <i>Q3</i>
<i>R</i>	Aliens residing in the U.S. under orders of supervision [I-220B]	Emergency Only <i>R1</i>	Emergency Only <i>R2</i>	Emergency Only <i>R3</i>
<i>S</i>	Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record]	Emergency Only <i>S1</i>	Emergency Only <i>S2</i>	Emergency Only <i>S3</i>

	UNQUALIFIED ALIEN GROUPS (cont.)	Arrived Before 8-22-96	Arrived On or After 8-22-96	
<i>T</i>	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]	Emergency Only <i>T1</i>	Emergency Only <i>T2</i>	Emergency Only <i>T3</i>
<i>U</i>	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]	Emergency Only <i>U1</i>	Emergency Only <i>U2</i>	Emergency Only <i>U3</i>
<i>V</i>	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only <i>V1</i>	Emergency Only <i>V2</i>	Emergency Only <i>V3</i>
<i>W</i>	Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-1186; SW-434; I-95A]	Emergency Only <i>W1</i>	Emergency Only <i>W2</i>	Emergency Only <i>W3</i>
	GRANDFATHERED ALIEN GROUPS			
<i>X</i>	Unqualified aliens or emergency services qualified aliens who <ul style="list-style-type: none"> • were eligible for and receiving Medicaid LTC services in medical facilities or CBC waivers on 6-30-97, and • who continue to reside in LTC medical facilities or continue to receive CBC Medicaid CBC waiver services 	Full Benefits <i>X1</i>	Full Benefits <i>X2</i>	Full Benefits <i>X3</i>
<i>Y</i>	Unqualified aliens or emergency services qualified aliens under age 19 years who meet the alien status requirements that were in effect before 7-1-97	Full Benefits <i>Y1</i>	Full Benefits <i>Y2</i>	Full Benefits <i>Y3</i>

Commonwealth of Virginia
Department of Social Services

APPLICANT'S NAME: <hr/> CASE NUMBER: <hr/>
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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 #: _____ 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: _____ 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 complete the worker 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 and the date, keeps the carbon 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 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.

**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 inquiry.

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 TANF, SSI, or Medicaid, or Food Stamp 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 form 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: _____

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.

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				YEAR	QC PATTERN			
	1 ST Q	2 ND Q	3 RD Q	4 TH Q		1 ST Q	2 ND Q	3 RD Q	4 TH Q
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

State's Name & Address _____

Contact Person's Name & Telephone Number _____

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS**M0240.001 GENERAL PRINCIPLE**

- A. Policy** To be eligible for Medicaid, an individual must provide his/her Social Security account number (SSN) as well as the Social Security account numbers of any children for whom Medicaid is requested, or must provide proof of application for a Social Security account number, UNLESS the applicant
- is an illegal alien as defined in subchapter M0220, or
 - is a child under age 1 as defined in *M0320.301 B. 2.*
- B. Failure to Meet This Requirement** Any Medicaid family unit member for whom an application for a Social Security number has not been filed or for whom the SSN is not furnished **is not eligible** for Medicaid EXCEPT for:
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 as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met.
 2. an illegal alien as defined in Section [M0220](#); an illegal alien does not have to provide or apply for a social security number.
- C. Verification** The individual's Social Security number is verified by the IEVS system when the individual is entered in that system.
- D. Procedure** Section M0240.100 below explains in detail how to determine if an individual meets the Social Security number requirements when the individual or child does not have an SSN.

M0240.100 APPLICATION FOR SSN

- A. Policy** If a Social Security account number 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.
- In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that a Social Security number 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.

C. F&C Covered Groups

A child who is **temporarily** living away from his/her parent's home is considered living with the parent and the family unit policy in subchapter M0520 applies.

If the child is living apart from the parent or is receiving LTC services, only the income and resources which the parent actually makes available to the child are counted.

M0250.500 SUPPORT FROM ABSENT PARENT**A. Policy**

A parent/caretaker who is applying for Medicaid for himself and on behalf of a child who has an absent parent must cooperate with the agency and DCSE in establishing the paternity and in obtaining medical support for the Medicaid eligible child, unless the:

- parent/caretaker is an MI pregnant woman and is requesting assistance for herself and her child born out of wedlock, or
- the parent/caretaker has good cause for not cooperating, or
- the parent/caretaker is only eligible under the Family Planning Services (FPS) covered group.

Explain and offer 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.

If the parent/caretaker is required to cooperate with the agency in the pursuit of support from an absent parent as a condition of eligibility and refuses or fails to cooperate, he/she is ineligible for Medicaid. The parent's refusal or failure to cooperate does not affect the child's eligibility for Medicaid.

B. DCSE

DCSE District Offices were established in all regions and have the responsibility of pursuing support from absent legally responsible parent(s) and establishing paternity when the alleged father is absent from the home. 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.

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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

- M0320.300 Families & Children Categorically Needy Groups
- M0320.301 MI Pregnant Women & Newborn Child
- M0320.302 Family Planning Services
- M0320.303 MI Child Under Age 19
- M0320.305 IV-E Foster Care or IV-E Adoption Assistance Recipients
- M0320.306 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.

- 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 made 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 that 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. Asset Transfer

The protected individual must meet the asset transfer policy in *subchapter M1450*.

c. 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).

d. 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

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

- 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.*

M0320.201 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/she 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. Eligibility for months prior to SSI entitlement must be evaluated in other covered groups.
- C. Financial Eligibility**
- a. Asset Transfer**
 - 1. Resources** The SSI recipient must meet the asset transfer policy in *subchapter M1450*. See *subchapter M1450* to determine if the asset transfer

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.

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 the SSI recipients covered group. His retroactive eligibility must be evaluated in another Medicaid covered group.

Eligible SSI recipients are classified as categorically needy (CN). Program designation is

- 11 for an aged SSI recipient;
- 31 for a blind SSI recipient;
- 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 \leq 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/she meets the assignment of rights to medical support and third party payments requirements (see M0250) and the asset transfer policy in *subchapter M1450*. 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 classified as categorically needy (CN). Program designation is

- 12 for an aged AG recipient;
- 32 for a blind AG recipient;
- 52 for a disabled AG recipient.

M0320.203 ABD IN MEDICAL INSTITUTION, INCOME \leq 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/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 institutionalized in a medical institution that is not an IMD;
 8. Application to the Health Insurance Premium Payment Program (HIPP);
 9. 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/she 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:

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).

7. Is not living in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the Aged, Blind, or Disabled definition in M0310. **If the individual has not been determined disabled, he/she is “deemed” to be disabled because of the terminal illness. Do not refer the individual to the MDU.**

The individual must elect hospice care. Election of hospice care is verified either orally or in writing from the hospice. If the verification is oral, document case record.

C. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in *subchapter* M1450. Hospice care is **not** a long-term care service, so any asset transfer penalty will not preclude Medicaid payment for hospice services.

2. Resources

a. Resource Eligibility

The hospice services recipient is an assistance unit of 1 person. **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.**

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 has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

Deem any resources from the individual’s spouse living in the home in accordance with policy in subchapter M1480. If the individual is a child, do **not** deem any resources from the child’s parent.

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.

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 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/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 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/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 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 twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 2 to chapter S11).

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.

**6. Spenddown
Period Ends**

After the spenddown period ends, reinstate the SLMB-only coverage using the PD 53.

The begin date of the reinstated PD 53 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 "24". Reinstatement of 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 Medicaid 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".

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.

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 do not exceed twice the SSI resource limit; 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 limit for a QI is twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 2 to chapter S11 for resource requirements and 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 Coverage Period

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. Coverage under this group cannot begin earlier than January 1 of the calendar year. The Notice of Action on Medicaid must state the recipient's **begin and end dates** of Medicaid coverage.

QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year.

E. 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.**

F. Enrollment**1. Program Designation**

QI = 56

2. Eligibility Type

The eligibility type is "Type 1" for ongoing.

3. Begin and End Dates

The begin date of coverage cannot be any earlier than January 1 of the calendar year.

Do not enter an end date of coverage. The MMIS will automatically cancel the recipient's coverage on December cut-off, effective December 31 of the calendar year.

4. Recipient's Covered Group Changes To QI**a. Before November Cut-off**

An enrolled recipient's PD cannot be changed to PD "56" 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 "07". Reinstatement of the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate program designation.

b. 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 "07".

**G. MMIS
Procedures For
QI Recipients**

The MMIS computer 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.

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 twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 1 to chapter S11).

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.

C. 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 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 \leq 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

- 5. Income Exceeds 80% FPL** **Spendedown does not apply** to this covered group. If the individual's income exceeds the 80% FPL limit, he/she is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

- 1. Begin Date** Eligibility in the ABD 80% FPL covered group cannot begin earlier than July 1, 2001. 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, but no earlier than July 1, 2001.

- 2. Retroactive Entitlement** ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period, but no earlier than July 1, 2001.

E. Enrollment

The program designations are:

- 29 for an aged recipient;
- 39 for a blind recipient; or
- 49 for a disabled recipient.

**5. Income
Changes
After
Eligibility
Established**

Changes in an MI pregnant woman's income do not affect her and her newborn's eligibility once her eligibility is established, as long as she meets the pregnant definition and the other nonfinancial Medicaid eligibility requirements, when she meets the following conditions:

- a. she applies for Medicaid no later than the date her pregnancy terminates and
- b. she is eligible for Medicaid effective the date her pregnancy terminates.

If she applies for Medicaid after the date her pregnancy terminated, or the woman's Medicaid entitlement begins after the date pregnancy terminated, any changes in her income affect her eligibility.

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 \$1,000 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 requirement.

**6. Income
Exceeds MI
Limit**

Spenddown does not apply to the medically indigent. If the applicant's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy 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.

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

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 resources or 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 resource and income limits, because of the different resource and income rules and the different resource and income limits used in the F&C and ABD determinations.

2. Asset Transfer

The asset transfer rules in subchapter M1450 must be met by an LIFC individual.

3. Resources

The resource requirements in chapter M06 must be met by the LIFC group.

NOTE: For VIEW participants, the motor vehicle exclusion is different.

The CNNMP resource limit is in M0610.002. If the family’s resources exceed the limit, the family unit is not eligible as LIFC; divide the family unit into budget units and redetermine eligibility if appropriate. If not, redetermine the family unit’s countable resources using the medically needy policy in chapter M06 for those family members who meet an MN covered group.

NOTE: There is no comparable medically needy group for families with children. The children may meet the “children under age 18” MN covered group, but the caretaker-relative must be either pregnant, aged, blind or disabled to meet an MN covered group.

- individuals in adoptions subsidized in full or in part by a public agency;
- individuals in nursing facilities;
- individuals in intermediate care facilities for the mentally retarded (ICF-MRs).

When a child is under age 19, first determine the child's eligibility in the MI *Child Under Age 19* covered group (M0320.303). If the child is *ineligible* as MI, and the child meets the requirements of the "individuals under age 21" covered group, enroll the child in Medicaid using one of the PDs in item D. below.

B. Nonfinancial Eligibility

The child must be under age 21 and must meet the nonfinancial requirements in chapter M02.

1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115, but who are not IV-E eligible, are "individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility." When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

a. Child Placed in Home For Trial Visit

A child also meets the non-IV-E foster care definition when placed by the agency in the child's own home for a "trial" period of up to three months if the child continues to be in the agency's custody.

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 in the local social services agency's legal custody. A foster child in a non-custodial agreement who is in an independent living situation meets this requirement and is eligible in this covered group.

2. Juvenile Justice Department Children

Children under age 21 in foster homes or private institutions for whom the Juvenile Justice Department is assuming full or partial financial responsibility are "individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility." These children also meet the non-IV-E foster care definition in M0310.115. When Juvenile Justice Department children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

A child also meets the non-IV-E foster care definition when placed by Juvenile Justice in the child's own home or a foster home if the child receives services from locally or regionally operated outreach detention programs which receive reimbursement from the Juvenile Justice Department.

Jails, learning centers, reception and diagnostic centers, and secure and less secure detention homes, even though they may have a capacity of 16 beds or less, are ineligible institutions and children housed therein are not eligible for Medicaid. Children temporarily sent to hospitals and/or psychiatric centers from a special placement in an ineligible institution with the intent to return to that ineligible institution are **not** eligible for Medicaid.

**3. 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.”

Do not include non IV-E adoption assistance children who have “special medical needs” in this covered group. See M0320.308 below for special medical needs adoption assistance children.

**4. In ICF or
ICF-MR**

Children under age 21 who are patients in nursing facilities meet this covered group. Children under age 21 who are patients in intermediate care facilities for the mentally retarded (ICF-MRs) also meet this covered group.

**C. Financial
Eligibility**

**1. Assistance
Unit**

a. Foster Care Children

The child is a separate family unit of 1 person 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, **unless** the child(ren) is placed in his own home.

Foster care children who are placed in their own homes with their parents and siblings are evaluated as an assistance unit according to chapter M05, except during trial visits for up to three months. A foster care child continues to be a single person unit during a trial visit. A “trial visit” is no longer than three months for this section’s purposes.

If the unit’s income and/or resources exceed the *F&C limits*, the child is not categorically needy non-money payment. 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 foster care child and family members who meet an MN covered group are enrolled in Medicaid.

b. Adoptive Placement

Adoptive placement of a child who is in a public or private agency's custody does not always terminate the child's Medicaid eligibility. While in adoptive placement, the child meets the foster care definition and is an assistance unit of one person. Only the child's own income and resources are counted. The prospective adoptive parent's(s') income/resources are **not** counted or deemed available to the child until the entry of the interlocutory or final order of adoption, whichever comes first.

c. Final Adoption and Non-IV-E Adoption Assistance

Final adoption of any child, from either a public or private agency, terminates the child's Medicaid eligibility under the foster care definition. If the child receives an adoption assistance payment, or if the child was adopted under an adoption assistance agreement, then the child meets the "adoption assistance" definition.

Financial eligibility is determined using the assistance unit procedures in chapter M05, which require the inclusion of the child's adoptive parent(s). An adoption assistance child who is not a "special medical needs" child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's(s') income and resources available. If the child is adopted under a "special medical needs" adoption assistance agreement, see M0320.308 below. "Special medical needs" are defined in M0320.308 below.

2. Asset Transfer

The asset transfer rules in subchapter M1450 must be met by the child.

3. Resources

The resource limit and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible as categorically needy non-money payment. Determine the child's eligibility as medically needy in the MN covered group of "reasonable classifications of individuals under age 21." Redetermine countable resources using the MN resource requirements, which differ from the F&C CNNMP resource requirements.

4. Income

The income limits and requirements are found in chapter M07.

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 unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

**C. Financial
Eligibility**

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 adoption assistance child's own income and resources are counted.

2. Asset Transfer The asset transfer rules in subchapter M1450 must be met by the child.

3. Resources The resource limits and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible as CNNMP. Determine the child's eligibility as MN in the MN covered group of individuals under age 21. Redetermine countable resources using the MN resource requirements, which differ from the CNNMP resource requirements.

4. Income Adoption assistance children in residential facilities do not have a different income limit. The CNNMP income limit (F&C 100% income limit) for one person in the child's locality is used to determine eligibility as categorically needy non-money payment. For an adoption assistance child living outside the State of Virginia, the income limit for the unit 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 CNNMP 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 PD for individuals in the CNNMP covered group of special medical needs adoption assistance children is "72."

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;
8. Application to the Health Insurance Premium Payment Program (HIPP).

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

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.**

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*. Hospice care is **not** a long-term care service, so any asset transfer penalty will not preclude Medicaid payment for hospice services *for Medicaid eligible individuals*.

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

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.

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The CDC Breast and Cervical Cancer Early Detection Program has income and resource requirements that are used to screen women for this program.

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 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 or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

The BCCPTA Medicaid Application/Redetermination, form #032-03-384, was developed for this covered group only. The application includes the Breast and Cervical Cancer Early Detection Program 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/ Redetermination.

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 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.

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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;
8. Application to the Health Insurance Premium Payment Program (HIPP).

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

5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP).

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. Reinstatement of 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". Reinstatement of the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is blind MN dual-eligible QMB "48."

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.

M0330.203 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;
8. Application to the Health Insurance Premium Payment Program (HIPP).

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

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).

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;
8. Application to the Health Insurance Premium Payment Program (HIPP).

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 the individual is not eligible because of excess resources and she has Medicare Part A, determine if she 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 the woman's resources are NOT within the limit, she is NOT eligible for Medicaid.

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 Changes After Eligibility Established

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, and she meets the following conditions:

- a. she applies for Medicaid no later than the date her pregnancy terminates **and**
- b. she is eligible for Medicaid or meets spenddown on or before the date her pregnancy terminates.

If she applies for Medicaid **after** the date her pregnancy terminated, or her **Medicaid entitlement begins after** the date pregnancy terminated, any changes in her income affect her eligibility.

6. Example--PG Woman Applies Before Pregnancy Ends

EXAMPLE #1: A married pregnant woman applies for Medicaid on October 10. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning \$1,000 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 she no longer meets other nonfinancial or resource eligibility requirements.

**7. Example--PG
Woman Applies
After
Pregnancy
Ends**

EXAMPLE #2: (using April 2003 figures)

A pregnant woman applies for Medicaid on October 10. Her child was born on October 7. She has been unemployed and has received unemployment compensation of \$400 per week since August 23. Her income exceeds the MI and MN income limits for 2 persons; she was placed on a spenddown which she met on October 20. She was enrolled October 20 through December 31 (end of 60-day postpartum period) and her child was enrolled in Medicaid effective October 20 through March 31. On November 20, she reported that she began receiving child support from the child's father in the amount of \$200 per month. She received the first payment on November 19. Her income changed after she established eligibility. However, the change in income affects her and her child's eligibility because she applied for Medicaid after the date of her child's birth and her Medicaid entitlement began after the date her pregnancy ended. Her spenddown is recalculated and increased. Because she did not meet the increased spenddown amount and she would not be eligible for Medicaid if she were pregnant, her Medicaid coverage is cancelled effective December 31.

**8. 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 Volume XIII, Part II Chapter F for spenddown policy and procedures.

If she meets a retroactive spenddown, and she applied on or before the date her pregnancy ended, income changes do not affect her eligibility through the 60-day postpartum period. So, she remains eligible through the end of the month in which the 60th day occurs regardless of any changes in her income.

If she has Medicare Part A, determine if she 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 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.

2. Covered Group Eligibility Ends

The child no longer meets this covered group effective:

- a. the end of the month during which the child ceases to live with the mother;
- b. the end of the month in which the child reaches age 1 year; or
- c. the end of the month in which the mother no longer meets one of the following nonfinancial requirements (she would be **ineligible** even if she were pregnant):
 - Citizenship/alien status (M0220);
 - Virginia residency (M0230);
 - Social security number provision/application requirements (M0240);
 - Assignment of rights to medical benefits requirements (M0250);
 - Cooperation in pursuing support (M0250);
 - Application for other benefits (M0270);
 - Institutional status requirements (M0280);
 - Application to the Health Insurance Premium Payment Program (HIPP) (M0290).
- d. effective the end of the spenddown period.

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), program designation "99."

M0330.303 CHILDREN UNDER AGE 18

. 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 UnderAge 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;
8. Application to the Health Insurance Premium Payment Program (HIPP).

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.

b. Adoptive Placement

Adoptive placement of a child who is in a public or private agency's custody does not always terminate the child's Medicaid eligibility. While in adoptive placement, the child meets the foster care definition and is an assistance unit of one person. Only the child's own income and resources are counted. The prospective adoptive parent's(s) income/resources are not counted or deemed available to the child until the entry of the interlocutory or final order of adoption, whichever comes first.

c. Final Adoption and Non-IV-E Adoption Assistance

Final adoption of any child, from either a public or private agency, terminates the child's Medicaid eligibility under the foster care definition. If the child receives an adoption assistance payment, or if the child was adopted under an adoption assistance agreement, then the child meets the "adoption assistance" definition. Financial eligibility of an adoption assistance child is determined using the assistance unit procedures in chapter M05, which require the inclusion of the child's adoptive parent(s), unless the child is adopted under a "special medical needs" adoption assistance agreement.

d. Special Medical Needs Adoption Assistance

"Special medical needs" are defined in, and the policy and procedures for special medical needs adoption assistance children are contained in, section M0330.305 below.

2. Resources

The resource limit and requirements are found in chapter M06.

If the resources exceed the MN limit, the child is not eligible for Medicaid as medically needy. If the child is under age 19, determine his/her eligibility in the *MI Child Under Age 19* covered group.

3. Income

The income limits and requirements are found in chapter M07.

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.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

If the unit's 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 foster

C. Financial Eligibility

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 adoption assistance child's own income and resources are counted.

2. Asset Transfer The asset transfer rules in *subchapter* M1450 must be met by the child.

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. 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 PD (program designation) for individuals in the MN covered group of special medical needs adoption assistance children is "86."

**MEDICALLY INDIGENT CHILD UNDER AGE 19
100% FPL
ALL LOCALITIES
INCOME LIMITS
EFFECTIVE 2/07/03**

<u># of Persons in Family/Budget Unit</u>	<u>Annual Limit</u>	<u>Monthly Limit</u>
1	\$ 8,980	\$ 749
2	12,120	1,010
3	15,260	1,272
4	18,400	1,534
5	21,540	1,795
6	24,680	2,057
7	27,820	2,319
8	30,960	2,580
each add'l person add	\$ 3,140	\$ 262

MI Child under age 6 with income less than or equal to 100% FPL
(PD 91)

MI Child age 6 to 19 with income less than or equal to 100% FPL
(PD 92)

**MEDICALLY INDIGENT CHILD UNDER AGE 19
PREGNANT WOMAN
133% FPL
INCOME LIMITS
ALL LOCALITIES
EFFECTIVE 2/07/03**

<u># of Persons in Family/Budget Unit</u>	<u>Annual Limit</u>	<u>Monthly Limit</u>
1	\$11,944	\$ 996
2	16,120	1,344
3	20,296	1,692
4	24,472	2,040
5	28,649	2,388
6	32,825	2,736
7	37,001	3,084
8	41,177	3,432
each add'l person add	4,177	348

Pregnant Woman with income less than or equal to 133% FPL
(PD 91)

MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL
(PD 90)

Insured MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL, **effective 9-1-02**
(PD 92)

Uninsured MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL, **effective 9-1-02**
(PD 94)

<p align="center">185% of FEDERAL POVERTY LIMITS TWELVE MONTH EXTENDED AND TRANSITIONAL MEDICAID INCOME LIMITS ALL LOCALITIES EFFECTIVE 2/7/03</p>		
<u># of Persons in Family/Budget Unit</u>	<u>Annual Limit</u>	<u>Monthly Limit</u>
1	\$16,613	\$1,385
2	22,422	1,869
3	28,231	2,353
4	34,040	2,837
5	39,849	3,321
6	45,658	3,805
7	51,467	4,289
8	57,276	4,773
each add=1 person add	5,809	484

**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.

<ul style="list-style-type: none"> Categorically Needy-Non Money Payment 300% of SSI 	
Family Size Unit 1	Monthly Amount \$1,656

**4. Medically
Needy**

a. Group I		
Family Unit Size 1	Semi-annual \$1,380.48	Monthly \$230.08
2	\$1,758.04	\$293.00
b. Group II		
Family Unit Size 1	Semi-annual \$1,592.86	Monthly \$265.47
2	\$1,961.71	\$326.95
c. Group III		
Family Unit Size 1	Semi-annual \$2,070.72	Monthly \$345.12
2	\$2,496.77	\$416.12

**5. ABD
Medically
Indigent**

**For:
ABD 80%
FPL, QMB,
SLMB, & QI
without Social
Security (SS)
and QDWI,
effective
2/07/03; and
ABD 80%
FPL, QMB,
SLMB, & QI
with SS,
effective 4/1/03**

ABD 80% FPL 1	Annual \$7,184	Monthly \$ 599
2	\$9,696	\$ 808
QMB 100% FPL 1	Annual \$8,980	Monthly \$ 749
2	\$12,120	\$1,010
SLMB 120% of FPL 1	Annual \$10,776	Monthly \$ 898
2	\$14,544	\$1,212
QI 135% FPL 1	Annual \$12,123	Monthly \$1,011
2	\$16,362	\$1,364
QDWI 200% of FPL 1	Annual \$17,960	Monthly \$1,497
2	\$24,240	\$2,020

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.

- 4. When Deducted** A health insurance premium is deducted from the spenddown liability on the date the premium is due. The worker cannot deduct a pre-paid premium that is paid before the date it is due. The worker must deduct only the amount of the premium that is due on the due date.
- When a health insurance premium is deducted from the individual's check, the premium is due on the date of the check. 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 3; the individual receives it on December 5. The Medicare Part B premium is deducted from the individual's spenddown liability on December 3.
- 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,
 - 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.

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.

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,

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 Mental Health Mental Retardation (MHMR) facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state MHMR facilities. When an enrolled ABD Medicaid recipient is admitted to a state MHMR 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. Who Can Apply** The individual, his/her authorized representative (person authorized to conduct business for the applicant) can file the application for Medicaid and make the assignment of rights and the declaration of citizenship.

**6. Invalid
Application
Procedure**

An application that is not signed by the applicant or his authorized representative, as required above in this section, is invalid. If the application was mailed to or dropped off at the agency, the agency must send a letter to the applicant requesting the required signature(s). If the application was made with the help of an EW at the agency, the EW must give a letter to the person who made the application requesting the required signature(s). A sample letter is in *subchapter M0120, Appendix 1*

Record an invalid application and enter it into the computer tracking system. Do not extend the pending application past the 45 days unless:

- the adult applicant is unable to sign or make a mark AND a court guardianship hearing is scheduled or the applicant requires Adult Protective Services to locate an authorized representative;
- the child applicant requires Child Welfare services intervention or has a guardianship or custody hearing scheduled.

**7. Redetermina-
tion
Application
Procedures**

When preparing to redetermine the Medicaid eligibility of an individual age 18 or older, review the case record to determine if the recipient completes and signs the review application form, or if the recipient has an authorized representative. Ask the following questions:

Has the recipient been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate in the record?

Yes: authorized representative is the appointed guardian or conservator. STOP.

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

Yes: authorized representative is the attorney-in-fact. STOP.

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

Yes: authorized representative is the person or organization authorized by the individual to represent him. STOP.

No: Is the recipient able to sign or make a mark on a Medicaid application form?

D. Procedures

1. **Application Completion**

Signed application is received. See *chapter M01* for application requirements.

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.

The individual's eligibility is determined as an institutionalized individual if he is in a medical institution, or if the individual has been screened and approved for nursing facility or CBC services. If applicant is eligible, the EW completes the Medicaid enrollment.

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, a recipient 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

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?

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, or

CHAPTER M18
MEDICAL SERVICES

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M18 MEDICAL SERVICES

MEDICAL SERVICES

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Appendix

Foster Care Child Exemption from Medicaid Managed Care Programs	Appendix 1	1
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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). A new card is issued each month as long as the recipient remains eligible. 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 monthly Medicaid card:

- individuals eligible for Medicare premium payment only,
- individuals in a nursing facility, and
- recipients enrolled in a Medallion II Managed Care Organization (MCO).

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.

The recipient must be advised that it is his responsibility to return his Medicaid card to the local social services department when he is no longer eligible for Medicaid.

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 do not receive Medicaid cards. The nursing facility 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. Therefore, the patient will receive a Medicaid card until DMAS 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. If the facility fails to notify the LDSS when a patient is discharged to the community, the patient will not receive a Medicaid card until the LDSS is notified of the discharge. Long-term care providers have been instructed to notify the LDSS of death or discharge via the DMAS-122.

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 from DMAS and are available online at www.dmas.state.va.us.

**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.

**2. 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 recipients 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 recipients. Both programs require recipients 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. Recipients
Exempt from
Managed Care**

General

The following recipients 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), and recipients approved for Medicaid community-based care waiver services;

- Qualified Medicare Beneficiaries (QMB), dually-eligible recipients, Special Low-income Medicare Beneficiaries (SLMB), Qualified Individuals, and Qualified Disabled and Working Individuals (QDWI);
- recipients 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;
- recipients enrolled in the Aged, Blind or Disabled (ABD) with Income \leq 80 % Federal Poverty Level (FPL) covered group;
- women enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group;
- women enrolled in the Family Planning Services (FPS) covered group;
- recipients who receive hospice services in accordance with DMAS criteria;
- refugees; and
- recipients on a spenddown.

MEDALLION

The following recipients are excluded from participating in MEDALLION:

- recipients who are not accepted to the caseload of any participating PCP, and
- recipients 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 recipients are excluded from participating in Medallion II:

- recipients, 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 Mental Health, Mental Retardation and Substance Abuse Services 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 a Program Designation (PD) of 74, 76, or 86 are automatically excluded from participating in managed care. Foster Care/Adoption Assistance children who are enrolled under any other PD 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 (see Appendix 1 to this chapter). The custody order must be attached to the form in order to process enrollment.
- Fax the form to the Managed Care Helpline at (804) 698-5602.

The Managed Care Helpline collects all of the information and forwards it to DMAS for processing. Exemption requests may take up to 5 business days to complete. Disenrollment is effective at the end of the month of notification (not retroactively). Once a child is removed from managed care, a fee-for-service Medicaid card is generated. The LDSS can verify disenrollments by checking page 3 of the eligibility file in MMIS or by calling the Managed Care Helpline.

2. Other Exempt Recipients

Recipients other than Foster Care/Adoption Assistance children not enrolled in PD 74, 76, or 86 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.dss.state.va.us 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:

The 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-122.

B. Client Medical Management Program

Recipients' utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by the Department of Medical Assistance Services. 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 the Department of Medical Assistance Services. The local agency service worker will be asked to interview the recipient and gather information for DMAS. Following receipt of that information by the Department of Medical Assistance Services, the recipient's Medicaid card 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 1-886-386-8331.

Recipients Enrolled in Managed Care

Recipients enrolled in managed care should be referred to the Managed Care Helpline at 1-800-643-2273. 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 1-886-386-8331. Medallion II enrollees who need assistance with transportation must contact their MCO directly.

B. Copayments

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. 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 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;
- 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;
- optometrist services;
- 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;
- transplant services; and
- transportation to receive medical services.

Explanations of some covered services are provided below:

1. 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.

2. 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 Immundeficiency Syndrome (AIDS) Waiver,
- Elderly and Disabled (E&D) Waiver,
- Consumer-directed Personal Attendant Services (CD-PAS) Waiver,
- Mental Retardation (MR) Waiver,
- Technology Assisted Waiver, and
- Individual and Family Developmental Disabilities (DD) Support Waiver

Services covered under the waivers are listed in M1410.040.

3. 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 Mental Retardation (MR) Waiver. Other community mental retardation services are available to recipients enrolled in the MR Waiver and include mental retardation case management, day support, residential support, and supported employment services.

4. Dental Services

a. For Recipients Under Age 21

Covered dental services include emergency 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 DMAS.

b. For Recipients Over Age 21

Covered dental services are limited to those provided under Title XVIII of the Social Security Act (Medicare) which are:

- surgery of the jaw or any structure contiguous to the jaw and
- the reduction of any fracture of the jaw or any facial bone.

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.

5. Early 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 Program (EPSDT). 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 for which federal financial participation is available, for a child under age 21 if the service is 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 a local social services board 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

- 11. Medical Supplies and Equipment**
- Medicaid will cover blood glucose self-monitoring test strips for children with diabetes under the age of 21 and pregnant women with gestational diabetes.
- 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.
- 12. Nurse-Midwife Services**
- Services are covered when provided by a licensed Medicaid-enrolled nurse-midwife, as allowed under Virginia law.
- 13. 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.
- 14. Optometrist Services**
- Eye examinations that licensed optometrists and opticians 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.
- 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. 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 recipients 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.
- 22. Transportation to Receive Medical Services**
- Non-emergency transportation to a medical service is covered only when preauthorized by the DMAS transportation broker.
- Transportation is only covered when the recipient is being transported for the purpose of receiving or returning home from a Medicaid-covered service.

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

Disenrollments are not retroactive and will be effective the end of the month of notification. In order for exemptions to occur in a timely manner, please notify the Helpline as soon as possible. To confirm disenrollments, check page 3 of the Eligibility file for the managed care segment end date or call the Managed Care Helpline.

A Copy of the Custody Order Must be Attached to Process the Disenrollment.

Send form to: Managed Care Helpline
Telephone: 1-800-643-2273
Fax: 804-698-5602

MEDICAID ID# _____	Name _____
Address _____	Date _____
_____	City/County Code _____
_____	Case Worker _____

MEDICAID ID# _____	Name _____
Address _____	Date _____
_____	City/County Code _____
_____	Case Worker _____

<p align="center">FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 2/0703</p>				
<p># of Persons in FAMIS Assistance Unit</p>	<p>FAMIS 150% FPL</p>		<p>FAMIS 200% FPL</p>	
	<p>Annual Limit</p>	<p>Monthly Limit</p>	<p>Annual Limit</p>	<p>Monthly Limit</p>
1	\$13,470	\$1,123	\$17,960	\$1,497
2	18,180	1,515	24,240	2,020
3	22,890	1,908	30,520	2,544
4	27,600	2,300	36,800	3,067
5	32,310	2,693	43,080	3,590
6	37,020	3,085	49,360	4,114
7	41,730	3,478	55,640	4,637
8	46,440	3,870	61,920	5,160
each add'l person add	4,710	393	6,280	524

LOCAL CHOICE AGENCIES- 07/30/02

Altavista, Town of
Amelia County School Board
Amelia County Board of Supervisors
Amherst County Board of Supervisors
Amherst County Service Authority
Bath, County of
Blue Ridge Regional Jail Authority
Bluefield, Town of
Brookneal, Town of
Brunswick County Public Schools
Buckingham, County of
Carroll County Board of Supervisors
Carroll County Public Schools
Cedar Bluff, Town of
Central Shenandoah Planning District Commission
Central Virginia Regional Jail
Chesapeake Bay Bridge & Tunnel District
Clintwood, Town of
Coeburn, Town of
Coeburn-Norton-Wise Regional Waste Water
Colonial Heights, City of
Covington City School Board
Craig County School Board
Crater Youth Commission
Cumberland Mountain Community Services Board
Danville Redevelopment and Housing Authority
Dayton, Town of
Dickenson County Department of Social Services
Dinwiddie County Public Schools
Dinwiddie County Water Authority
Dinwiddie, County of
District 19 Community Services Board
District Three Governmental Cooperative
Dublin, Town of
Eastern Shore Community Service Board
Farmville, Town of
Franklin, City of
Franklin City Public Schools
Fredericksburg City Public Schools
Front Royal, Town of
Glade Spring, Town of
Gordonsville, Town of
Greensville County School Board
Grundy, Town of
Hampton Roads Regional Jail Authority
Haysi, Town of
Highlands Juvenile Detention Center Commission
Honaker, Town of
J.R. Horsley Soil and Water Conservation District
John Flannagan Water Authority
Jonesville, Town of
King George, County of
King William, County of
Lebanon, Town of
Lee County Department of Social Services
Lee County Government
Lee County Public Service Authority
Lenowisco Planning District Commission
Lunenburg County Public Schools
Luray, Town of
Mathews County
Middle Peninsula Regional Security Center
Monacan Soil & Water Conservation District
Mount Jackson, Town of
Mount Rogers Planning District Commission
Narrows, Town of
Nelson, County of
New Market, Town of (only if employee hired
before 12/16/96)
New River Valley Agency on Aging
New River Valley Planning District Commission
Northern Shenandoah Valley Regional
Commission
Norton City Public Schools
Norton, City of
Page County Government
Pearisburg, Town of
Pembroke, Town of
Pennington Gap, Town of
Peter Francisco Soil and Water Conservation
District

Petersburg, City of
Powhatan County Public Schools
Powhatan, County of
Prince Edward County Public Schools
Prince William Soil & Water Conservation District
Purcellville, Town of
Rich Creek, Town of
Richlands, Town of
Richmond County Employees
Roanoke Valley-Alleghany Regional Commission
Saint Paul, Town of
South Central Wastewater Authority
Southampton County
Southampton County School Board
Spotsylvania County School Board
Sussex County School Board
Tazewell County
Tazewell County Department of Social Services
Tidewater Soil and Water Conservation District
Timberville, Town of
Virginia Biotechnology Research Park Authority
Virginia Peninsulas Public Service Authority
Virginia Port Authority
Westmoreland County
Williamsburg-James City County Public Schools
Wise County Board of Supervisors
Wise County School Board
Wise, Town of
Woodstock, Town of