



COMMONWEALTH of VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

June 2, 2003

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #74

The following acronyms are used in this transmittal:

- AA - Adoption Assistance
- BCCPTA - Breast and Cervical Cancer Prevention and Treatment Act
- CDPAS - Consumer Directed Personal Attendant Services
- DCSE - Division of Child Support Enforcement
- DDS - Disability Determination Services
- E&D - Elderly and Disabled
- F&C - Families and Children
- FAMIS - Family Access to Medical Insurance Security Plan
- FC - Foster Care
- LDSS - Local Departments of Social Services
- LTC - Long-term Care
- MDU - Medicaid Disability Unit
- MI - Medically Indigent
- QI - Qualified Individuals
- QMB - Qualified Medicare Beneficiary
- SLMB - Special Low-income Medicare Beneficiary
- SSA - Social Security Administration
- SSI - Supplemental Security Income
- TANF - Temporary Assistance for Needy Families
- VA - Veteran's Administration
- VIEW - Virginia Initiative for Employment Not Welfare

This transmittal contains revised policies and procedures that are effective July 1, 2003 for the Medicaid program and August 1, 2003 for the FAMIS program. Included in these changes are the elimination of Transitional Medicaid for former VIEW participants; revision to the policy, procedures and forms for referrals for disability determinations; and changes in the counting of VA Aid and Attendance and pension payments in the patient pay calculation. Also included in this transmittal are clarifications for LTC prescreening requirements; for handling FC and AA children's cases; for handling DCSE referrals; and for deducting health insurance premiums in a medically needy spenddown. Additionally, the transmittal includes clarifications for the Hospice and the BCCPTA covered groups.

The annual increases in the monthly maintenance needs and excess shelter standards used to determine the community spouse income allowance are included in this transmittal and must be used for patient pay calculations beginning July 1, 2003. If a redetermination is processed

on or after July 1, 2003, and the change in the standards decreases the patient pay amount, adjust the patient pay amount to reflect any overpayments using the procedures in M1470.900 C.1. VA Aid and Attendance and pension payments in excess of \$90 must be counted in the patient pay calculation for nursing facility patients, including patients in the Veteran's Care Center, beginning with the next patient pay recalculation, but no later than January 2004.

This transmittal also includes revisions to the policy on referrals for disability determinations. The disability determination process has been streamlined with the consolidation of the MDU into DDS. Subchapter M0310 contains the revised procedures and forms that must be used when a referral to DDS is required. Links have been created in the online manual to download the new forms from the internet. Do not use the Medical History and Disability Report (032-03-007), the Medical History and Disability Report Psychological/Psychiatric Supplement (032-03-007a), the General Authorization for Medical Information (032-03-511), or the Permission to Release Medical Information (032-03-399) after July 1, 2003 for Medicaid disability determinations. The Disability Referral Form (032-03-095) has been revised and renamed the Disability Determinations Services (DDS) Referral Form and must also be used beginning July 1, 2003.

Transitional Medicaid coverage for former VIEW participants expired June 30, 2003. No new enrollments under Transitional Medicaid may be made after June 30, 2003. Local agencies were provided with a list of cases enrolled in Transitional Medicaid during the month of May and instructions for reviewing and if necessary, redetermining continuing Medicaid eligibility for these individuals.

As part of our continuing efforts to provide health insurance coverage for children, the 2003 General Assembly enacted several changes which will become effective August 1, 2003. The period of ineligibility for dropping private health insurance without good cause in the FAMIS program is reduced from 6 months to 4 months. In addition, the name "FAMIS" will be used to designate Virginia's Children's Health Insurance Programs. The Title XXI program will continue to be known as FAMIS, and the Title XIX MI Child Under Age 19 Medicaid covered group will be known as FAMIS Plus. This name denotes the different benefit packages provided to recipients under Title XIX and Title XXI.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0120 pages 9, 10	Subchapter M0120 pages 9, 10	On page 9, clarified policy on applications for FC and AA children. Page 10 is a reprint.
Chapter M02 Table of Contents	Chapter M02 Table of Contents	Added appendices for subchapter M0220.
Subchapter M0220 pages 7, 8	Subchapter M0220 pages 7, 8	On page 7, corrected the reference for aliens receiving SSI. Page 8 is a reprint.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0250 pages 5, 6	Subchapter M0250 pages 5, 6	On page 5, clarified age requirements for children referred to DCSE. Page 6 is a reprint.
Chapter M03 Table of Contents	Chapter M03 Table of Contents	Added appendices for subchapter M0310.
Subchapter M0310 Table of Contents pages 7, 8 pages 21-30a pages 37-39	Subchapter M0310 Table of Contents pages 7, 8 pages 21-30 pages 37-39 Appendices 1-4	In the Table of Contents, added Appendices 1-4. On page 7, revised the definition of blindness and the referral process for the determination of blindness. Page 8 is a reprint. On pages 21-28, revised the definition of disability and the referral process for the disability determination. On page 29, deleted the TANF covered group and added the BCCPTA covered group. On page 30, clarified the hospice definition. On page 37, clarified the definition of the QI covered group and added the poverty level percentage for the QMB covered group. On page 38, added the poverty level percentage for the SLMB covered group. On page 39, revised the definition of the BCCPTA covered group to include a specific age range. Added Appendices 1-4 (the Disability Report-Adult, the Disability Report-Child, the Authorization to Disclose Information to SSA, and the DDS Referral Form).

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0320 pages 31, 32 pages 50a, 50b pages 65-70	Subchapter M0320 pages 31, 32 pages 50a, 50b pages 65-70	On pages 31 and 32, clarified policy for individuals receiving hospice services in a nursing facility. On page 50a, added the FAMIS Plus reference to MI Child Under 19 covered group. On page 50b, updated the reference for covered services. Page 65 is a reprint. On pages 66 and 67, clarified policy for individuals receiving hospice services in a nursing facility. Page 68 is a reprint. On page 69, clarified age range for BCCPTA covered group. Page 70 is a reprint.
Subchapter M0510 pages 3, 4	Subchapter M0510 pages 3, 4	On page 3, deleted specific application names under the definition of family unit. On page 4, updated the reference to chapter M14 for institutionalized individuals.
Subchapter M0710 pages 7-13	Subchapter M0710 pages 7-13	Page 7 is a reprint. On pages 8-13, clarified that Workforce Investment Act income and earned income of a student under age 19 are excluded. On page 8, updated the references to the F&C MI covered groups
Subchapter M0720 page 3, 4	Subchapter M0720 pages 3, 4	On page 3, clarified the income base period definition. Page 4 is a reprint.
Subchapter M1340 pages 1-4	Subchapter M1340 pages 1-4	On pages 1 and 3, revised when the health insurance premium is deducted. Page 2 is a runover page. Page 4 is a reprint.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1420 pages 3, 4	Subchapter M1420 pages 3, 4	Page 3 is a reprint. On page 4, clarified that a pre-admission screening is not required for an individual transferring from nursing home care to E&D or CDPAS waiver services.
Subchapter M1460 pages 31, 32	Subchapter M1460 pages 31, 32	On pages 31 and 32, added references to section M1470.100 for counting VA Aid and Attendance and pension payments as income for patient pay.
Subchapter M1470 pages 1, 2	Subchapter M1470 pages 1, 2	Page 1 is a reprint. On page 2, revised policy for counting VA Aid and Attendance and pension payments over \$90 per month as income for patient pay.
Subchapter M1480 pages 65, 66	Subchapter M1480 pages 65, 66	Page 65 is a reprint. On page 66, revised the monthly maintenance needs standard and the excess shelter standard effective July 1, 2003.
Subchapter M1510 Table of Contents pages 3, 4 pages 7-8a	Subchapter M1510 Table of Contents pages 3, 4 pages 7, 8	Corrected the page number on the Table of Contents. On page 3, updated examples #2 and #3. On page 4, revised the policy for evaluating applications of disabled applicants in the retroactive period. On pages 7 and 8, revised and clarified the policy for disability denials and subsequent SSA decisions.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1520 pages 5, 6 pages 13, 14 pages 21-24	Subchapter M1520 pages 5, 6 pages 13, 14 pages 21-24	Page 5 is a reprint. On page 6, revised and clarified the redetermination policy for the MI Child Under Age 19 covered group. On pages 13 and 22, noted the expiration of Transitional Medicaid effective June 30, 2003. Pages 14, 21 and 24 are reprints. Page 23 is a runover page.
Chapter M21 pages 1, 2 pages 5, 6 page 11	Chapter M21 pages 1, 2 pages 5, 6 page 11	Pages 1 and 5 are reprints. On pages 2 and 6, revised policy to decrease the period of ineligibility due to discontinuing insurance coverage to 4 months, effective August 1, 2003. On page 11, added policy for 12-months continuous eligibility for FAMIS.

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



Duke Stoen, Director
Division of Benefit Programs

Attachments

is used to apply for a child under age 19 years who must be evaluated for eligibility in the FAMIS program (See M0120, Appendix 3a); and

- Title IV-E Foster Care & Medicaid Application/Redetermination, form # 032-03-636 (see M0120, Appendix 8).

C. Other Medicaid Applications

1. Auxiliary Grant (AG)

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

2. Title IV-E Foster Care (FC) and Medicaid Application/Redetermination (Form #032-03-636)

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

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

D. Recipient Changes Assistance Unit

A new application must be completed when an active Medicaid recipient becomes a member of a different assistance unit.

M0120.400 Place of Application

A. Principle

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

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

B. Children in State and Local Custody

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

1. Foster Care

a. Title IV-E Foster Care

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody.

Title IV-E Foster Care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

b. State/Local Foster Care

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

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

2. Adoption Assistance

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

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

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

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

C. Institutionalized Individual (Not Incarcerated)

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

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

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M0220.300 FULL BENEFIT ALIENS**A. Policy**

A “full benefit” alien is

- an alien who receives SSI (M0220.305);
- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) (M0220.306);
- a “qualified” alien (defined in M0220.310 below) who entered the U.S. before 8-22-96;
- a qualified alien refugee, asylee, deportee, Amerasian, Cuban or Haitian entrant, 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-

Determination and Education Assistance Act (25 U.S.C. 450b(e)). Section M0220.306 describes this group of aliens.

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

3. Step 3

Third, determine if the alien is a “qualified” alien eligible for full benefits (a full benefit qualified alien).

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

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

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

4. Step 4

Fourth, determine if the alien is a “grandfathered” alien. Section M0220.314 defines the grandfathered aliens.

If the alien is NOT a grandfathered alien, go to Step 5.

If the alien is a grandfathered alien, go to Step 6.

5. Step 5

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

6. Step 6

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

M0220.305 ALIENS RECEIVING SSI

A. Policy

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

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

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 *under age 18 (DCSE will not pursue medical support for children age 18 and over unless a court order has extended support beyond age 18)* 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.

- C. Cooperation with DCSE** Medicaid recipients (except an MI pregnant woman under certain conditions in D. below, child-only cases in G. below, and FPS woman in H. below) are required to cooperate with paternity establishment and securing medical support as a condition of eligibility for Medicaid. Cooperation in the establishment or enforcement of a child support obligation is optional and Medicaid recipients may refuse these services not related to medical support or paternity establishment.
- D. Exception For MI Pregnant Women** An MI pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.
- E. No Exception For MN Pregnant Women** If a pregnant woman has countable income over the MI limit, she may be eligible for medically needy (MN) Medicaid if her resources are within the MN limit, she meets a spenddown and she meets all nonfinancial requirements including cooperation in pursuing support. An MN pregnant woman must cooperate with the agency in obtaining medical support for herself and any child for whom she applies from a legally responsible relative, unless she has good cause for not cooperating.
- F. Child Born to Medicaid Eligible Pregnant Woman** When a child is born to a Medicaid eligible woman and is enrolled in Medicaid, contact the parent with whom the child lives as soon as administratively possible, but no later than 60 days after the child's birth to explain and offer DCSE services.
- A child born to a Medicaid eligible pregnant woman remains eligible for Medicaid even when the parent/caretaker refuses to cooperate with DCSE in establishing paternity and pursuing support. The parent/caretaker's refusal to cooperate with DCSE results in the parent/caretaker's ineligibility for Medicaid, regardless of the covered group, but does not impact the child.
- G. Child-Only Cases** In child-only cases, cooperation with DCSE in the establishment of paternity and the pursuit of support is not a condition of the child's eligibility. DCSE services are available to all Medicaid recipients, but the parent/caretaker's refusal or failure to cooperate with DCSE will not affect the child's Medicaid eligibility.
- H. Family Planning Services (FPS) Covered Group** For the FPS covered group, cooperation with DCSE in the establishment of paternity and pursuit of support is not a condition of eligibility. The woman's refusal or failure to cooperate with DCSE does not affect her eligibility in this covered group (see M320.302).
- I. Procedures For Pursuing Support** The procedures for pursuing support from absent parents are different depending on whether or not the parent/caretaker is also a Medicaid applicant/recipient.

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M0310.105 AGE and AGED**A. Age**

“Age” is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

Eligibility in a Medicaid covered group often depends on an individual's age.

B. Aged

“Aged,” means age 65 years or older.

C. Procedures

For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual's age by Social Security records or documents in the individual's possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician's record;
- court record of adoption;
- baptismal record;
- midwife's record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

M0310.106 BLIND**A. Definition**

Blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye.

The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

B. Procedures

An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient's SSI eligibility via SVES (State Verification Exchange System).

Individuals who meet the visual eligibility are certified by the Department for the Blind and Vision Impaired (DBVI) and are listed in the Virginia Registry of the Blind. Call DBVI at 1-800-622-2155 to verify that an individual has been certified as blind.

An individual who requires a determination of blindness must be referred to the Disability Determination Services (DDS) using the procedure in M0310.112 E. 1.

M0310.107 CARETAKER-RELATIVE**A. Definitions****1. Caretaker-
relative**

A "caretaker-relative" is an individual who is not a parent, but who

- is a relative, of the specified degree, of a dependent child (as defined in M0310.111) and
- is living with and assuming continuous responsibility for day to day care of the dependent child in a place of residence maintained as his or their own home.

A caretaker-relative is also referred to as a "non-parent caretaker" to distinguish the caretaker-relative from the parent.

**2. Specified
Degree**

A relative of specified degree (a relative to the fifth degree of relationship) of the dependent child is

- any blood relative, including those of half-blood and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great;
- a stepfather, stepmother, stepbrother, and stepsister;
- a relative by adoption following entry of the interlocutory or final order, whichever is first; the same relatives by adoption as listed above: including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great, and stepfather, stepmother, stepbrother, and stepsister.
- spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.

Neither severance of parental rights nor adoption terminates the relationship to biological relatives.

B. Procedures**1. Relationship**

To verify the caretaker's relationship to the child, obtain documents which are in individual's possession:

- birth certificate or notification of birth
- hospital or physician's record
- court record of adoption
- baptismal record
- midwife's record of birth
- form VS95 from state Bureau of Vital Statistics

and child care centers) is the school or center's records showing the child's address and relative's name and relationship. The secondary sources if the child attends school are:

- hospital or physician's records,
- court or public agency records,
- contact with public housing,
- contact with landlord.

For pre-school age children who are not in nursery school, pre-school or a child care center, the individual's declaration of the child living with him/her will be accepted unless the worker has reason to question the accuracy of the individual's statement. Document the case record to show the verification or declaration used.

If unable to obtain verification from any source listed above, the case record must be documented to reflect all attempts made to secure verification from a primary or secondary source. The case record must also contain documentation of the evidence the worker obtained which substantiates the child's presence in the caretaker-relative's home.

b. Temporary Absence From Home

A child under age 21 who is living away from home is considered living with his/her parent(s) in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes or non medical (residential) institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

M0310.112 DISABLED

A. Introduction

The Social Security Administration (SSA) defines disability for an individual who is age 18 or older as the inability to do any substantial gainful activity (work) because of a severe, medically determinable

physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 continuous months, or which is expected to result in death.

SSA defines disability for a child under age 18 as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. However, a child cannot be found disabled if, at application, the child is performing substantial gainful activity and is not currently entitled to SSI benefits.

The Disability Determination Services (DDS) is a division of the Virginia Department of Rehabilitative Services (DRS). DDS is charged with making the determinations of medical eligibility for disability or blindness benefits under Social Security (SS), Supplemental Security Income (SSI), and Medicaid. DDS works in partnership with the SSA, the Department of Medical Assistance Services (DMAS), and the Department of Social Services (DSS) in processing disability and blindness claims and makes its determinations of “disabled” or “not disabled” based upon federal regulations. The same definitions of disability and blindness and the same evaluation criteria are used for all three programs.

The Railroad Retirement Board (RRB) makes disability determinations for railroad employees. “Total” disability determinations mean the individual is disabled for all regular work. “Occupational” disability means the individual is disabled for regular railroad occupation, but not “totally” disabled. Individuals who receive a “total” disability determination are disabled using the same criteria as the SSA.

The Medicaid disability definition is the same as the SS, SSI, and the Railroad Retirement (RR) total disability definition.

B. Policy

Individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination and individuals who have been determined disabled by the RRB meet the Medicaid covered group requirement of being “disabled.”

C. Who Meets the Medicaid Disability Definition

An individual meets the Medicaid disability definition if he:

- receives SS/SSI as a disabled individual, or RR total disability benefits; or*
- has been found to be disabled by the DDS without a subsequent decision by SSA reversing the disability decision.*

An applicant who received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason other than no longer meeting the disability or blindness requirement continues to meet the disability or blindness definition.

An applicant who has not received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application must reapply for a disability determination.

A disability or blindness review is not required unless the applicant starts working, or the agency has reason to believe the applicant's condition has improved.

1. Individual Has Been Determined Disabled and receives Benefits From SSA

If an applicant alleges that he has been found to be disabled and is receiving SS/SSI disability benefits, verify his disability status through a SVES request or through documentation provided to the applicant by the SSA.

If the individual applies for retroactive coverage and the SSI decision or the SVES SSI information do not specify a disability onset date that covers the Medicaid application's retroactive period, refer the individual to DDS for a disability determination using the procedures in E. 1. below.

2. Individual Has Been Determined Totally Disabled by RRB

If an applicant alleges that he has been found to be totally disabled and is receiving RR benefits, verify his disability by contacting the RRB at 804-771-2997 or 1-800-808-0772, or through documentation provided to the applicant by the RRB.

3. Individual Has Been Determined Disabled by DDS

If the applicant alleges that he has been found to be disabled by the DDS but there is no disability determination on file, verify his status by contacting the DDS at 804-662-9222.

D. DDS Disability Determinations- General Information

An individual who is claiming a disabling condition and does not receive SS/SSI disability benefits, or RR total disability benefits and has not been denied disability or has not had disability determined by DDS, must have his disability determined by DDS.

The DDS makes a determination of disability when the:

- *applicant alleges a disabling condition and has never applied for disability from SSA or has not been denied disability within the past 12 months;*
- *SSA has not made a decision on a pending SS/SSI claim; or*
- *applicant alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.*

The DDS must make a disability determination within a time frame that will allow DSS to process the application within 90 days, provided all medical information has been submitted.

1. DSS Referral to DDS Required When Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. Follow the procedure in E. 1. below for making a referral to DDS.

2. DSS Referral to DDS Required When SSA Denied Disability Within Past 12 Months

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

- a. The applicant alleges a condition that is new or in addition to the condition(s) already considered by SSA,*

OR

- b. The applicant alleges his condition has changed or deteriorated causing a new period of disability, AND*

- he no longer meets the SSI financial requirements but might meet Medicaid financial requirements, or*
- he applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.*

If the conditions in a. or b. exist, DDS must make a disability determination. The eligibility worker must follow the procedure in E. 1. below to make a referral to DDS. Information regarding the new, changed and/or deteriorated condition(s) must be identified and sent to DDS using the procedure in E. 1. below.

If the conditions in a. or b. do not exist, the SSA denial of disability is final for Medicaid purposes. Do not make a referral to DDS for a disability determination.

3. Referral to DDS When SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, the eligibility worker must follow the procedure in E. 1. below to make a referral to DDS.

E. DDS Procedures When a Disability Determination is Required

1. Referral to DDS

The following forms must be completed and sent to DDS when requesting a disability determination:

- the [Disability Report Adult SSA-3368-BK](#) (see Appendix 1 to this subchapter) or the [Disability Report Child SSA-3820-BK](#), (see Appendix 2 to this subchapter) and
- an [Authorization to Disclose Information to the Social Security Administration form SSA-827-02-2003](#) (see Appendix 3 to this subchapter), and
- a DDS Referral Form - 032-03-095 (see Appendix 4 to this subchapter).

NOTE: The SSA disability reports and the Authorization to Disclose Information to the Social Security Administration are available on-line at <http://www.ssa.gov/online/#supporting>. The DDS Referral form is available on the DSS local agency page at <http://www.localagency.dss.state.va.us>

When the SSA disability report and the Authorization to Disclose Information to the Social Security Administration forms must be sent to the applicant for completion, send the request immediately, giving the applicant 10 days to return the completed forms. When the completed forms are returned, **mail** them along with the DDS Referral form to:

Disability Determination Services Unit
5211 West Broad Street, Suite 201
Richmond, Virginia 23230-3032

Do not send referrals to DDS via the courier.

The application is held in a pending status while a determination of disability is made.

If the completed forms are not returned by the applicant within 45 days from the date of application, the applicant does not meet the covered group and the Medicaid application must be denied.

2. Application for Other Benefits

Individuals with a work history, or individuals whose disability began prior to reaching age 22 years and whose parent(s) is retired (because of age or disability) or deceased must apply for Social Security or RR benefits as a disabled individual as a nonfinancial requirement of Medicaid eligibility. Refer individuals with a work history to the appropriate SSA Office to apply for benefits. Refer individuals who report a railroad work history to the Railroad Retirement Board (RRB) to apply for benefits. Applicants are not required to apply for SSI benefits.

Do not delay processing the Medicaid application while waiting for the applicant to apply for SSA/RR benefits. However, if the applicant does not apply for SSA/RR benefits within 45 days from the date of the Medicaid application, deny the Medicaid application due to "failure to

apply for benefits (SSA/RR) for which the individual might be entitled” (see M0270). Notify the DDS to stop action on the disability determination.

**F. Communication
Between Agency
and DDS**

**1. Eligibility
Worker
Responsibilities**

The eligibility worker must make every effort to provide the DDS with complete and accurate information. Report all changes in address, medical condition, and earnings to the DDS on pending applications.

If the eligibility worker is aware of changes in the applicant’s situation that would make him ineligible for Medicaid even with a favorable disability determination, the information must immediately be provided to the DDS so that office will not complete a disability determination. When an application is denied for a nonfinancial reason not related to the disability determination, DDS must be notified immediately.

**2. DDS
Responsibilities**

The DDS will advise the local agency of the applicant’s disability status as soon as it is determined by either SSA or the DDS. The DDS will send the eligibility worker a notice to be sent to the applicant advising him of the outcome of his disability determination.

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. In the event that this situation occurs, the DDS will notify the applicant directly of the delay and/or the need for additional information. A copy of the DDS’s correspondence to the applicant will be sent to the local agency eligibility worker so a Notice of Action to extend the pending application can be sent

**G. Notice to the
Applicant**

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notification of the applicant’s disability status and send the client both the DDS’s notification of the disability determination and a Notice of Action of the agency’s decision on the Medicaid application.

**H. Applicant is
Deceased**

When an individual who applies for a disability determination and Medicaid dies or when the applicant is deceased at the time of the Medicaid application, the DDS will determine if the disability requirement for Medicaid eligibility was met. The eligibility worker must immediately notify DDS of the individual’s death and provide a copy of the death certificate, if available.

**I. Subsequent SSA or
RRB Disability
Decisions**

When SSA or the RRB make a disability decision subsequent to the DDS decision which differs from the DDS decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in D. 2. above applies.

a. SSA/RRB Approval

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the

decision is reversed, reevaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, but eligibility as a disabled individual cannot begin prior to the disability onset date.

b. SSA Denial, Termination and SSA Appeal

If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.

If the individual appeals timely (within 60 days from the SSA notification) the SSA disability decision and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case. The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further administrative review.

The levels of administrative review are in the following order:

- 1) reconsideration,*
- 2) the hearing before an administrative law judge (ALJ), and*
- 3) the Appeals Council.*

For example, an individual fails to appeal the ALJ decision to the Appeals Council and the Appeals Council does not decide on its own to review the case. The ALJ decision becomes the final decision once the 60-day deadline for requesting further review has passed. Because the individual no longer meets the disabled definition nor another covered group, his Medicaid coverage must be canceled.

c. RRB Denial, Termination and RRB Appeal

If RRB denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.

Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further If the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The individual must provide verification

that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.

M0310.113 EWB

A. Essential to The Well-Being (EWB)

EWB is the short name for a person who is “essential to the well-being” of a child in the household. An EWB who is living in the household and who is providing services which are essential to the well-being of the dependent, deprived child(ren) in the household may be eligible for Medicaid in the LIFC covered group, if the individual

- does not meet any other Medicaid covered group, and
- the individual to whom the EWB provides the service(s) is eligible for Medicaid in the CNNMP LIFC covered group. Services which are essential to the well-being of the dependent, deprived child(ren) in the household are listed in item B.

B. Services Essential to Well-Being

Services which are essential to the well-being of the dependent, deprived child(ren) in the household are limited to:

- provision of care for an incapacitated family member in the home;
- provision of child care which enables the caretaker to work on a full-time basis outside the home;
- provision of child care which enables the caretaker to receive training full-time;
- provision of child care which enables the caretaker to attend high school or GED classes full-time;
- provision of child care for a period not to exceed 2 months to enable the caretaker to participate in employment search.

C. Procedure

Section M0320.306 contains the detailed requirements for the LIFC covered group in which an EWB can be eligible for Medicaid.

M0310.114 FAMILIES & CHILDREN (F&C)

A. Families & Children (F&C)

"Families & Children (F&C)" is the group of individuals that consists of

- eligible members of families with dependent children,
- pregnant women, and
- specified subgroups of children under age 21.

B. Procedures

See the following sections for definitions of F&C individuals and families:

- M0310.102 Adoption Assistance,
- M0310.107 Caretaker-relative,
- M0310.110 Child,
- M0310.111 Dependent Child,
- M0310.113 EWB,
- M0310.115 Foster Care,
- M0310.118 LIFC,
- M0310.123 Parent,
- M0310.124 Pregnant Woman
- *M0310.133 BCCPTA*

M0310.115 FOSTER CARE**A. Definition**

Foster Care provides maintenance and care for children whose custody is held by:

1. a local board of social services;
2. a licensed private, non-profit child placement agency;
3. the Department of Juvenile Justice; or
4. the child's parent(s), under a non-custodial agreement with the child's parent or guardian and the local Board of Social Services or the public agency designated by the Community Policy & Management Team (CPMT).

1. Custody

Custody may be given either by the court or through a voluntary entrustment by the parent(s).

2. Child Placing Agency

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

3. Non-custodial Agreement

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services or the public agency designated by the Community Policy & Management Team (CPMT). The parent(s) or guardian retain legal custody of the child. The social services agency agrees to provide financial assistance and services to the child, such as placement in and payment for residential facility services.

Because the agency is assuming partial financial responsibility for the child, the child meets the foster care definition. However, the agency does not have legal custody of the child; therefore, the parent(s) or guardian must apply for Medicaid for the child.

B. Procedures**1. IV-E Foster Care**

Children in the custody of a Virginia local department of social services who are eligible for Title IV-E (AFDC-FC) foster care maintenance payments and who reside in Virginia are IV-E foster care for Medicaid eligibility purposes.

Children in the custody of another state's social services agency, who are eligible for Title IV-E foster care maintenance payments and who now reside in Virginia, are IV-E foster care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

2. Non IV-E Foster Care

Children in the custody of a Virginia local department of social services or a private child placing agency who are eligible for non IV-E (state/local) foster care maintenance payments and who reside in Virginia are non IV-E foster care for Medicaid eligibility purposes.

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "corrections child." The corrections child who meets the CNNMP F&C resource and income limits is IV-E foster care for Medicaid eligibility purposes. A corrections child is not eligible for IV-E foster care.

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

M0310.116 HOSPICE**A. Definition**

"Hospice" is a CNNMP covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. *The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility.*

1. Hospice Care

"Hospice care" means items and services *are* provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

2. Hospice Program

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes *or in medical facilities* on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

M0310.126 Qualified Individuals

A. Qualified Individuals (QI)

QI-1 is the short names used to designate the Medicaid covered group of "Qualified Individuals." A qualified individual means a Medicare beneficiary

- who is entitled to Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI, and
- whose income is equal to or more than 120% of the federal poverty level (FPL) and is less than 135% FPL.

B. Procedure

Qualified individuals is a mandatory covered group that the State Plan must cover for the purpose of paying the Medicare Part B premium for the QI. See section M0320.208 for the procedures to used to determine if an individual meets the QI covered group.

M0310.127 QMB

A. Qualified Medicare Beneficiary (QMB)

QMB is the short name used to designate the Medicaid covered group of "Qualified Medicare Beneficiary." A qualified Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI, and
- whose income does not exceed 100% of the FPL.

B. Procedure

QMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare premiums and cost sharing expenses. See section M0320.206 for the procedures to use to determine if an individual meets the QMB covered group.

M0310.128 RSDI

A. Retirement, Survivors & Disability Insurance (RSDI)

Retirement, Survivors & Disability Insurance (RSDI) is another name for Old Age, Survivors & Disability Insurance (OASDI) - the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

B. Procedure

RSDI is not used in the Medicaid manual. Because Title II of the Social Security Act is still officially called “Old Age, Survivors & Disability Insurance”, the Medicaid manual uses the abbreviation “OASDI” interchangeably with “Title II” to refer to Title II Social Security benefits.

M0310.129 SLMB**A. Special Low-income Medicare Beneficiary (SLMB)**

SLMB is the short name used to designate the Medicaid covered group of “Special Low-income Medicare Beneficiary”. A special low-income Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income exceeds the QMB income limit (*100% of the FPL*) but does NOT exceed the higher SLMB income limit, which is *120%* of the FPL.

B. Procedure

SLMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary’s Medicare Part B premium. See section M0320.208 for the procedures to use to determine if an individual meets the SLMB covered group.

M0310.130 SSI**A. Supplemental Security Income (SSI)**

Supplemental Security Income (SSI) is the federal cash assistance benefit program under Title XVI of the Social Security Act that provides cash assistance to eligible aged, blind or disabled individuals to meet their shelter, food and clothing needs.

B. Procedures

Individuals who receive SSI (SSI recipients) are not “automatically” eligible for Medicaid in Virginia. SSI recipients must meet all of the Medicaid nonfinancial eligibility requirements and must meet the Medicaid resource eligibility requirements that are more restrictive than SSI’s resource requirements. See section M0320.200 for the procedures to use to determine if an SSI recipient meets a covered group.

M0310.131 STATE PLAN**A. Definition**

The State Plan for Medical Assistance is a comprehensive written statement submitted by the Department of Medical Assistance Services (DMAS) describing the nature and scope of Virginia’s Medicaid program. It contains all the information necessary for the federal *Centers for Medicare and Medicaid Services (CMS)* to determine whether the state plan can be approved for federal financial participation (FFP) in the state’s Medicaid program expenses.

B. State Plan Governs Medicaid Eligibility Rules

The State Plan consists of preprinted material that covers the basic Medicaid requirements and individualized material written by DMAS that reflects the particular requirements and choices made by Virginia for its Medicaid program. The State Plan is included in DMAS' state regulations promulgated according to the Virginia Administrative Process Act (APA). The State Plan is kept and updated by DMAS.

The State Plan shows the eligibility requirements for Virginia Medicaid, including the mandatory and optional groups of individuals covered by Virginia Medicaid and the medical services covered by Medicaid for those groups. The covered groups eligibility requirements in this chapter are based on the State Plan.

M0310.132 TANF

A. Temporary Assistance for Families (TANF)

TANF is the federally-funded (with matching funds from the states) block grant program in Title IV Part A of the Social Security Act that provides temporary cash assistance to needy families. In Virginia, TANF replaced the previous Title IV-A program called Aid to Families With Dependent Children (AFDC) on February 1, 1997.

B. Procedures

If the individual is included on the TANF grant in a TANF case, he is a TANF recipient. Verify his inclusion on the grant from agency records and the ADAPT computer system.

M0310.133 BCCPTA

A. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

The Breast and Cervical Cancer Prevention and Treatment Act created a Medicaid covered group for women age *40 through 64* who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

B. Procedures

Section M0320.312 contains the detailed requirements for the BCCPTA covered group.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

**DISABILITY REPORT
ADULT**

For SSA Use Only

Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)

B. SOCIAL SECURITY NUMBER

C. DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)

Area Code _____ Number _____ Your Number Message Number None

D. Give the name of a friend or relative that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

City _____ State _____ ZIP _____ DAYTIME PHONE _____ Area Code _____ Number _____

E. What is your height without shoes? _____ feet _____ inches

F. What is your weight without shoes? _____ pounds

G. Do you have a medical assistance card? (For Example, Medicaid or Medi-Cal) If "YES," show the number here: YES NO

H. Can you speak English? YES NO If "NO," what languages can you speak? _____

If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages? (If this is the same person as in "D" above show "SAME" here.)

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

City _____ State _____ ZIP _____ DAYTIME PHONE _____ Area Code _____ Number _____

I. Can you read English? YES NO **J. Can you write more than your name in English?** YES NO

Disability Report-Adult-Form SSA-3368-BK

SECTION 2 YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work? _____

B. How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause you pain or other symptoms? YES NO

D. When did your illnesses, injuries or conditions first bother you?

Month	Day	Year
-------	-----	------

E. When did you become unable to work because of your illnesses, injuries or conditions?

Month	Day	Year
-------	-----	------

F. Have you ever worked? YES NO (If "NO," go to Section 4.)

G. Did you work at any time after the date your illnesses, injuries or conditions first bothered you? YES NO

H. If "YES," did your illnesses, injuries or conditions cause you to: (check all that apply)

- work fewer hours? (Explain below)
- change your job duties? (Explain below)
- make any job-related changes such as your attendance, help needed, or employers? (Explain below)

I. Are you working now? YES NO

If "NO," when did you stop working?

Month	Day	Year
-------	-----	------

J. Why did you stop working? _____

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the kinds of jobs that you have had in the last 15 years that you worked.

JOB TITLE <i>(Example, Cook)</i>	TYPE OF BUSINESS <i>(Example, Restaurant)</i>	DATES WORKED <i>(month & year)</i>		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY <i>(Per hour, day, week, month or year)</i>	
		From	To			\$	
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

D. In this job, did you:

Use machines, tools or equipment? YES NO

Use technical knowledge or skills? YES NO

Do any writing, complete reports, or perform duties like this? YES NO

E. In this job, how many total hours each day did you:

- Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____
- Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____
- Sit? _____ Crouch? *(Bend legs & back down & forward.)* _____ Write, type or handle small objects? _____
- Climb? _____ Crawl? *(Move on hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

G. Check heaviest weight lifted:

- Less than 10 lbs 10 lbs 20 lbs 50 lbs 100 lbs. or more Other _____

H. Check weight frequently lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

- Less than 10 lbs 10 lbs 25 lbs 50 lbs. or more Other _____

I. Did you supervise other people in this job? YES (Complete items below.) NO (Skip to next page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? YES NO

J. Were you a lead worker? YES NO

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

- A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? YES NO
- B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? YES NO

If you answered "NO" to both of these questions, go to Section 5.

C. List other names you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. List each **DOCTOR/HMO/THERAPIST/OTHER**. Include your next appointment.

1.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE <small>Area Code Phone Number</small>	CHART/HMO # (If known)		NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

2.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE <small>Area Code Phone Number</small>	CHART/HMO # (If known)		NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3. NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE <small>Area Code Phone Number</small>		CHART/HMO # (If known)	NEXT APPOINTMENT	
REASONS FOR VISITS				
WHAT TREATMENT WAS RECEIVED?				

If you need more space, use Remarks, Section 9.

E. List each HOSPITAL/CLINIC. Include your next appointment.

1. HOSPITAL/CLINIC			TYPE OF VISIT		DATES	
NAME			<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT	
STREET ADDRESS						
CITY	STATE	ZIP	<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT	
PHONE <small>Area Code Phone Number</small>						
			<input type="checkbox"/> EMERGENCY ROOM VISITS	DATE OF VISITS		

Next appointment _____ Your hospital/clinic number _____

Reasons for visits _____

What treatment did you receive? _____

What doctors do you see at this hospital/clinic on a regular basis? _____

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
STREET ADDRESS					
CITY			<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
STATE	ZIP				
PHONE			<input type="checkbox"/> EMERGENCY ROOM VISITS	DATE OF VISITS	
<i>Area Code</i>	<i>Phone Number</i>				

Next appointment _____ Your hospital/clinic number _____

Reasons for visits _____

What treatment did you receive? _____

What doctors do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

YES *(If "YES," complete information below.)* NO

NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE			NEXT APPOINTMENT	
<i>Area Code</i>			<i>Phone Number</i>	
CLAIM NUMBER (if any) _____				
REASONS FOR VISITS _____				

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? YES
 If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?
 YES NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part			
MRI/CT SCAN Name of body part			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of school completed.

Grade school:

0	1	2	3	4	5	6	7	8	9	10	11	12	GED
<input type="checkbox"/>													

College:

1	2	3	4 or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Approximate date completed: _____

B. Did you attend special education classes? YES NO (If "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

DATES ATTENDED _____ TO _____

City State Zip

TYPE OF PROGRAM _____

C. Have you completed any type of special job training, trade or vocational school?

YES NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

YES (Complete the information below) NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

DAYTIME PHONE NUMBER _____

Area Code Number

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

DISABILITY REPORT - ADULT - Form SSA-3368-BK**PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN
COMPLETING THIS FORM****IF YOU NEED HELP**

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at <http://www.ssa.gov/disability/3368/>.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Please fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means that you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or to result in death. So when we ask, "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 60 minutes to read the instructions, gather the necessary facts, and answer the questions.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0577

DISABILITY REPORT - CHILD

SECTION 1 - INFORMATION ABOUT THE CHILD

A. CHILD'S NAME (First, Middle Initial, Last)

B. CHILD'S SOCIAL SECURITY NUMBER

C. YOUR NAME (If agency, provide name of agency and contact person)

YOUR MAILING ADDRESS (Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)

CITY

STATE

ZIP CODE

D. YOUR DAYTIME PHONE NUMBER (If you have no phone number, give us a daytime number where we can leave a message for you.)

Area Code

Number

Your Number

Message Number

None

E. What is your relationship to the child?

F. Can you speak English? YES NO If "NO," what languages can you speak?

If you cannot speak English, give us the name of someone we may contact who speaks English and will give you messages.

NAME RELATIONSHIP TO CHILD

ADDRESS (Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME PHONE

Area Code

Phone Number

Can you read English? YES NO

G. Does the child live with you? YES NO If "NO," with whom does the child live?

NAME RELATIONSHIP TO CHILD

ADDRESS (Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME PHONE

Area Code

Phone Number

Can this person speak English? YES NO

If "NO," what languages can this person speak?

Can this person read English? YES NO

SECTION 1 – INFORMATION ABOUT THE CHILD

H. Can the child speak English? YES NO

If "NO," what languages can the child speak? _____

I. What is child's height (without shoes)? _____ What is child's weight (without shoes)? _____

J. Does the child have a **medical assistance card**? (for example, Medicaid, Medi-Cal)

YES NO

If "YES," show the **number** here: _____

SECTION 2 – CONTACT INFORMATION

Give the name of a person that we can contact (other than the child's doctors, such as legal guardian) who knows about the child's illnesses, injuries, or conditions and can help you with his/her claim.

NAME OF CONTACT _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ City State ZIP

DAYTIME PHONE NUMBER _____
Area Code Number

RELATIONSHIP TO CHILD _____

SECTION 3 – THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**? _____

B. How do the child's illnesses, injuries or conditions **limit his/her daily activities**? _____

C. When did the child become disabled?

Month	Day	Year
-------	-----	------

D. Do the child's illnesses, injuries or conditions cause **pain**? YES NO

SECTION 4 – INFORMATION ABOUT THE CHILD’S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

YES NO

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

YES NO

Tell us who may have medical records or other information about the child’s illnesses, injuries or conditions.

C. List each **DOCTOR/HMO/THERAPIST**. Include the child’s next appointment.

1.

NAME		DATES	
STREET ADDRESS		FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN
PHONE <i>Area Code</i> <i>Phone Number</i>	CHART/HMO #		NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

2.

NAME		DATES	
STREET ADDRESS		FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN
PHONE <i>Area Code</i> <i>Phone Number</i>	CHART/HMO #		NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

SECTION 4 – INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST

3.

NAME		DATES	
STREET ADDRESS		FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN
PHONE <small>Area Code Phone Number</small>	CHART/HMO #		NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

If you need more space, use Remarks, Section 10

D. List each HOSPITAL/CLINIC. Include child's next appointment.

1.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME	<input type="checkbox"/> INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
STREET ADDRESS	<input type="checkbox"/> OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
CITY STATE ZIP	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	
PHONE <small>Area Code Phone Number</small>			

Next appointment _____ The child's hospital/clinic number _____

Reasons for visits _____

What treatment did the child receive? _____

What doctors does the child see at this hospital/clinic on a regular basis? _____

SECTION 4 – INFORMATION ABOUT THE CHILD’S MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC			TYPE OF VISIT		DATES	
NAME			<input type="checkbox"/>	INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
STREET ADDRESS			<input type="checkbox"/>	OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	<input type="checkbox"/>	EMERGENCY ROOM VISITS	DATES OF VISITS	
PHONE						
Area Code	Phone Number					

Next appointment _____ The child's hospital/clinic number _____

Reasons for visits _____

What treatment did the child receive? _____

What doctors does the child see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 10

E. Does anyone else have medical records or information about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors) or is the child scheduled to see anyone else?

YES (If "YES," complete the information below.) NO

NAME			DATES	
ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE			NEXT APPOINTMENT	
Area Code			Phone Number	
CLAIM NUMBER (if any) _____				
REASONS FOR VISITS? _____				

If you need more space, use Remarks, Section 10

SECTION 5 – MEDICATIONS

Does the child currently take any **medications** for the illnesses, injuries or conditions? YES NO
 If "YES," tell us the following. (Look at the child's medicine bottles, if necessary.)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

If you need more space, use Remarks, Section 10

SECTION 6 – TESTS

Has the child had, or will he/she have, any **medical tests** for the illnesses, injuries or conditions?
 YES NO If "YES," please tell us the following: (give approximate dates, if necessary).

KIND OF TEST	WHEN DONE, OR WHEN IT WILL BE DONE (Month, day, year)	WHERE DONE (Name of Facility)	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY Name of body part _____			
SPEECH/ LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY Name of body part _____			
MRI/CAT SCAN Name of body part _____			

If the child has had other tests, list them in Remarks, Section 10.

SECTION 7 – ADDITIONAL INFORMATION

A. Has the child been tested or examined by any of the following?

- 1. Headstart (Title V) YES NO
- 2. Public or Community Health Department YES NO
- 3. Child Welfare or Social Service Agency YES NO
- 4. Women, Infant and Children (WIC) Program YES NO
- 5. Program for Children with Special Health Care Needs YES NO
- 6. Mental Health/Mental Retardation Center YES NO
- 7. Vocational Rehabilitation YES NO

If "NO" to 7 above and the child is over age 15, do you want the child to be referred to Vocational Rehabilitation? YES NO

If you answered "YES" to any of the above, complete B below.

B. 1. NAME OF AGENCY _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ City State - ZIP

PHONE NUMBER _____
Area Code Number

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

2. NAME OF AGENCY _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ City State ZIP

PHONE NUMBER _____
Area Code Number

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

If there are any other agencies, show them in Remarks, Section 10.

SECTION 8 – EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed? _____

B. Is the child currently attending school (*other than summer school*)? YES NO

If "NO" explain why the child is not attending school. _____

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City County State ZIP

PHONE NUMBER _____
Area Code Number

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? YES NO

If "YES," complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? YES NO

If "YES," and the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech therapy? YES NO

If "YES," and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

SECTION 8 – EDUCATION

D. List the names of all other schools attended in the last 12 months and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ *City* _____ *County* _____ *State* _____ *ZIP*

PHONE NUMBER _____
Area Code _____ Number

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? YES NO
 If "YES," complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? YES NO
 If "YES," and the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy? YES NO
 If "YES," and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

If there are other schools, show them in Remarks, Section 10.

E. Is the child attending Daycare/Preschool? YES NO
 If "YES," complete the following:

NAME OF DAYCARE/
 PRESCHOOL/CAREGIVER _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ *City* _____ *County* _____ *State* _____ *ZIP*

PHONE NUMBER _____
Area Code _____ Number

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

SECTION 9 – WORK HISTORY

A. Has the child ever worked (including sheltered work)? YES NO
If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____ City State ZIP

PHONE NUMBER _____
Area Code Number

NAME OF SUPERVISOR _____

B. List the job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 – REMARKS

Use this section for any added information you did not show in the earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

DISABILITY REPORT – CHILD - Form-SSA-3820-BK**READ ALL OF THIS INFORMATION
BEFORE YOU BEGIN COMPLETING THIS FORM****IF YOU NEED HELP**

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Fill out this form before your interview appointment.
- Print or type.
- **Do Not Leave Answers Blank.** If you do not know the answers or the answer is “none” or “does not apply,” write: “don’t know,” or “none,” or “does not apply.”
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the “REMARKS” section on Pages 10 and 11, and show the number of the question being answered.

ABOUT THE CHILD’S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child’s medical records.
- Copies of the child’s prescriptions.
- The child’s Individualized Education Program
- The child’s Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do

that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veteran Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 40 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form.

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form Approved
OMB No. 0960-0623

WHOSE Records to be Disclosed

NAME		
First	Middle	Last
SSN		Birthdate (mm/dd/yy)
SSA USE ONLY NUMBER HOLDER (If other than above)		
NAME		
SSN		

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

- All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases
 - Gene-related impairments (including genetic test results)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
- Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called 'disability determination services'), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

Determining whether I am capable of managing benefits ONLY (check only if applies)

EXPIRES WHEN

This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

Parent of minor Guardian Other personal representative (explain)

(Parent/guardian sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS

I know the person signing this form or am satisfied of this person's identity:

SIGN ▶

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)	Phone Number (or Address)
---------------------------	---------------------------

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,**"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a Form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by SSA to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA 827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223 (d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

Other than the above limited circumstances, SSA will not redisclose without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, state, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.**

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM

DISABILITY DETERMINATION SERVICES (DDS) REFERRAL FORM

TO: DISABILITY DETERMINATION SERVICES UNIT
5211 West Broad Street, Suite 201
Richmond, Virginia 23230-3032

RESERVED FOR DDS USE

Please print or type:

A. APPLICANT INFORMATION

SSN: _____ CASE #: _____

NAME: _____ BIRTH DATE: _____

MAILING ADDRESS: _____

MEDICAID APPLICATION DATE: _____ SSA/SSI APPLICATION DATE: _____

IF DECEASED, DATE OF DEATH: _____

Death certificate attached. Yes () No ()

B. REQUEST TO DDS: DISABILITY REPORT AND RELEASE FORM(S) MUST BE ATTACHED

_____ DETERMINE DISABILITY.

_____ DETERMINE DISABILITY/EXCEPTION APPLIES. SSA/SSI Disability denied in past 12 months. Evaluation by DSS shows the following exception applies:

_____ Applicant alleges a new condition that has not been considered by DDS/SSA;

_____ Applicant alleges his condition has changed or deteriorated AND

- he no longer meets SSI financial requirements, but might meet Medicaid financial requirements;

OR

- he has applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

_____ DETERMINE RETROACTIVE COVERAGE. Onset date requested: _____

Worker's Name Printed: _____ Worker Number: _____ FIPS Code: _____

Agency Name: _____ Phone # (____) _____

Agency Address: _____ FAX #: (____) _____

Date Mailed: _____

NOTE: This referral is not valid unless it is submitted by the Department of Social Services. If the applicant, another individual, or another agency completes this form, it should be sent to the local Department of Social Services. DDS cannot process forms that are incomplete or that do not have appropriate DSS identification and coding.

- 22 for an aged individual also QMB;
- 42 for a blind individual also QMB;
- 62 for a disabled individual also QMB.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is:

- 20 for an aged individual NOT also QMB;
- 40 for a blind individual NOT also QMB;
- 60 for a disabled individual NOT also QMB.

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.205 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and who elect hospice benefits.

In order to be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470).

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;

7. Is not 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 DDS.**

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

C. Financial Eligibility

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

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.

M0320.303 MI CHILD UNDER AGE 19 (*FAMIS PLUS*)**A. Policy**

Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits. Virginia has elected to cover children between the ages of 6 and 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. *Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.*

B. Nonfinancial Eligibility

The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

The child no longer meets this covered group effective the end of the month in which the child reaches age 19 years.

C. Financial Eligibility**1. Assistance Unit**

Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.

2. Asset Transfer

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

5. Income Changes

Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

6. Income Exceeds MI Limit

A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 - 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in *chapter M18*.

E. Enrollment

The PDs for the MI child are:

PD	Meaning
90	MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
91	MI child under age 6; income less than or equal to 100% FPL
92	<ul style="list-style-type: none"> • MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL; • MI child age 6-19; insured with income greater than 100% FPL and less than or equal to 133% FPL
94	MI child age 6-19; uninsured with income greater than 100% FPL and less than or equal to 133% FPL

Do not change the PD when a child's health insurance is paid for by Medicaid through the HIPP program.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

3. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 and subchapter M1460**. Determine what is income according to subchapter S0815, ABD What Is Not Income *and subchapter M1460, LTC Financial Eligibility*. DO NOT subtract the \$20 general exclusion or any other income exclusions.

The F&C waiver services individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (*see M0810.002 A. 3.*). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

If the total gross income **exceeds** the 300% of SSI income limit, the individual is **not** eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is “62.”

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is “60.”

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals,

redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.311 F&C HOSPICE

A. Policy

SMM 3580-3584 - The State Plan includes the covered group of children under age 21, pregnant women and parents or caretaker-relatives of dependent children who are terminally ill and who elect hospice benefits.

In order to be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470).

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the child, pregnant woman, or parent or caretaker-relative of a dependent child definition in subchapter M0310.

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

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources**a. Resource Eligibility - Unmarried Individual**

When determining resources for an unmarried F&C hospice individual, use the Medicaid F&C resource requirements in chapter **M06**. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of \$1,000.

DO NOT DEEM any resources from a child's parent living in the home.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility - Married Individual

When determining resources for a married F&C hospice individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C hospice individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

3. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08**. Determine what is income according to subchapter S0815, ABD What Is Not Income. DO NOT subtract the \$20 general exclusion or any other

income exclusions.

The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% SSI income limit (*see M0810.002 A. 3.*). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in the hospice covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in the hospice covered group. Evaluate his/her eligibility as medically indigent or medically needy.

D. Entitlement & Enrollment

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

1. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in M0320.205.

2. Enrollment

Enroll with program designation "54" for an individual who meets an F&C definition.

E. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. Evaluate the individual in a medically indigent or medically needy covered group.

M0320.312 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services for certain women with breast and cervical cancer. Virginia has chosen to cover this group beginning July 1, 2001.

Women eligible for the BCCPTA program must be age 40 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program and referred to LDSS for a Medicaid eligibility determination. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status;
- Virginia residency;
- social security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- MI Pregnant Women;
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance;
- a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits.

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.

for the Families & Children (F&C) covered groups is called the “family unit” or the “budget unit.”

The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD. In this situation, the assistance unit is the married ABD couple.

C. Budget Unit

The budget unit (BU) is the term used for the assistance unit for F&C individuals in a family when specific circumstances exist. The BU is a sub-unit of the family unit (FU). It contains some, but not all, members of the family unit.

D. Family Unit

The family unit is the name for the assistance unit when determining eligibility for an F&C individual or family. The family unit consists of all individuals listed on the application form as living in the household and among whom legal responsibility for support exists.

Federal Medicaid law and regulations prohibit deeming resources or income from anyone other than a parent to a child under age 21 or from spouse to a spouse. An individual cannot be ineligible or have his spenddown liability increased because of counting income and resources of non-legally responsible individuals living in the household.

The family unit must be further divided into “budget units” when the family unit does not meet the resource or income limit, and

- the family unit contains a stepparent, an acknowledged father not married to the mother, a married Medicaid minor or a Medicaid minor parent in the home, or
- a child in the family unit has resources or income of his/her own.

The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse) unless the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Spouse refers to a person who would be defined as married to the individual under applicable state law. Parent refers to the natural or adoptive parent of the child.

E. Deeming

Deeming is the process of considering the income and resources of another person, who is not included in the assistance, family or budget unit, to be the income and resources of the individual who is applying for or receiving Medicaid. Deemed income and resources are counted available to the eligible individual whether or not they are actually made available to him/her.

The federal Medicaid regulations require that the income and resources of certain individuals other than the applicant be included (deemed available) when determining an individual's Medicaid eligibility. These individuals

are the individual's responsible relatives--the individual's parent when the individual is under age 21 and the individual's spouse, except when the parent or spouse receives SSI or IV-E assistance payments. Except for a spouse of an individual, or a parent for a child who is under age 21, the agency must not consider resources and income of any relative as available to an individual.

Resources and income deemed to an individual are not considered resources or income in subsequent deeming calculations of the individual's resources or income.

F. Deemor

A deemor is an individual whose income and resources are subject to deeming. Such individuals include ineligible parents and ineligible spouses. It does not matter whether these individuals have sufficient income or resources to deem, they are still considered to be deemors. The type of income such an individual receives (e.g., public income maintenance payments such as TANF, VA pension based on need, etc.) does not exclude him/her from this definition for an ABD determination. For F&C determinations, recipients of SSI or IV-E payments are NOT deemors.

G. Illegal Deeming

Illegal deeming is a procedure which results in counting or deeming resources or income to an individual from a person who is not the individual's spouse, or who is not the individual's parent if the individual is under age 21.

M0510.200 GENERAL PROCEDURES

A. Introduction

This section contains the general policy and procedure for determining the individual's assistance unit for the financial eligibility determination.

B. Institutionalized Individuals

When an individual is institutionalized in a medical facility or Medicaid waiver services, the individual is an assistance unit of one person. *Go to chapter M14 to determine eligibility for institutionalized individuals.*

C. Non Institutionalized Individuals

1. Child Under Age 19

a. Does Not Receive SSI

Determine the child's F&C MI eligibility first (if pregnant, use the 133% pregnant woman limits), even if child is also foster care or adoption assistance. If the child has excess income for MI, then determine the child's MN eligibility for spenddown. Use the F&C family/budget unit policy in M0520.

If the child is also blind or disabled and does NOT receive SSI, determine F&C MI eligibility first. Use the F&C family/budget unit policy in

6. Examples**a. Example #2**

The client's weekly pay for the prior month was:

\$220.40
\$175.80
\$210.00
\$195.70

To obtain a monthly amount, multiply the weekly average by 4.3.

\$801.90 (total of the pay stubs) divided by 4 (number of paystubs) equals \$200.48 (average weekly amount).

$\$200.48 \times 4.3 = \862.06 monthly income.

b. Example #3

The client's bi-weekly pay for the prior month was:

\$185.40
\$209.50
\$394.90

To obtain a monthly amount, multiply the bi-weekly average by 2.15.

\$394.90 (total of the pay stubs) divided by 2 (number of pay stubs) equals \$197.45 (average bi-weekly amount).

$\$197.45 \times 2.15 = \424.52 monthly income.

c. Example #4

The client's salary is \$100 weekly. The pay does not vary. The client is paid every Friday.

The client reports she quit her job and will receive a final weekly paycheck on September 3. Since the client was paid for a partial month, the exact amount of \$100 will be used.

d. Example #5

The client reports she quit her job on June 21. She will receive a final bi-weekly paycheck on July 5.

For the month of May, she received \$190 and \$220 for a total of \$410. This amount is divided by two (the number of pays) to determine the average bi-weekly pay of \$205. \$205 is used to calculate her July Medicaid eligibility.

B. Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably certain he will receive.

3. Handling Changes in Income

When a change in income occurs, redetermine Medicaid eligibility.

C. Documentation

1. What the File Must Contain

Verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid).

The case record must be documented to reflect the method used to arrive at the anticipated income.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, employer, or representative.

M0710.700 DETERMINING ELIGIBILITY BASED ON INCOME

M0710.710 CATEGORICALLY NEEDY (CN)

A IV-E Foster Care/Adoption Assistance recipient's money payment meets the income eligibility criteria in the F&C CN classification. No separate income eligibility determination is completed for Medicaid.

M0710.720 MEDICALLY INDIGENT (MI)

The following procedures apply to the Medically Indigent classification:

A. Income Charts

The countable income of all FU/BU members allowing income exclusions when appropriate, is compared to the *medically indigent* income limits. Refer to subchapter M0710, Appendix 6 for the MI Income Limits.

B. Gross Income

Total gross income includes all gross earned income, *other than Workforce Investment Act income and income of a child under age 19 who is a student*. It also includes unearned income of all FU/BU members and any income deemed available to the family/budget unit.

C. Excluded Income

The following income is excluded when income is compared to MI limits:

1. All unearned income specifically excluded per M0730.099;
2. Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the assistance unit whose income is not otherwise exempt per M0720.520;
 - child care/incapacitated adult care exclusion per M0720.540

D. Income Eligibility

If the countable income (gross income minus above exclusions) is equal to or less than the MI income limit for that covered group, the members of the FU/BU meeting that classification are income eligible. If the countable income exceeds the income limit, the FU/BU is not eligible as MI.

Determine if any members of the FU/BU would be eligible as CNNMP or MN.

M0710.730 CATEGORICALLY NEEDY NON-MONEY PAYMENT (CNNMP)

The following procedures apply to the Categorically Needy Non-Money Payment (CNNMP) classification:

A. Individuals under 21 in Nursing Facilities or ICF/MR

Individuals under 21 in nursing facilities or ICF/MR are evaluated as individuals in medical facilities and their income is screened at 300% of SSI (see M0810.002 A. 3.).

B. Individuals under 21 in Foster Care/Adoption Assistance

Individuals under 21 in foster care or receiving adoption assistance are evaluated as Medically Indigent if they are under age 19 or pregnant. If they are not eligible as MI, evaluate their eligibility as CNNMP using the following procedures:

1. Step 1- 185% Screen

The child's countable income is the total gross earned *income, other than Workforce Investment Act income and income of a child under age 19 who is a student. It also includes unearned income, other than the unearned income listed in M0730.099.*

Screen income at LIFC 185% of the standard of need. Refer to M0710, Appendix 1 for the LIFC 185% of Standard of Need Chart.

If the countable income exceeds the LIFC 185% standard of need, the child is not eligible as an Individual Under 21 in FC/Adoption Assistance. If the income is equal to or less than LIFC 185% standard of need, proceed to Step 2.

**2. Step 2 -
100 % Screen**

Once the total countable income of the child is determined to be less than or equal to LIFC 185% standard of need, the child's income must be screened at F&C 100% income limit in the locality where the child resides outside an institution. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for F&C 100% Income Limit for one person.

Total gross income is all earned income, *other than Workforce Investment Act income and the income of a child under age 19 who is a student. It also includes* unearned income of the child, including contributions. The following income is excluded when income is screened at 100%:

- a. All unearned income specifically excluded in M0730.099;
- b. Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the family/budget unit whose income is not otherwise exempt per M0720.520;
 - child care/incapacitated adult care exclusion per M0720.540.

If the countable income (gross income minus above exclusions) is equal to or less than the F&C 100% income limit, the child is eligible as an Individual Under 21 in FC/Adoption Assistance.

If the countable income exceeds F&C income limit, evaluate eligibility as MN.

**C. LIFC (Non-View)
1. Step 1 -
185% Screen**

In order to meet the income requirements for Medicaid in the Low Income Families with Children (LIFC) covered group, the family/budget unit's countable income must be screened at LIFC 185% standard of need and the F&C 90% income limit (prospective determination) to determine the family/budget unit's eligibility. If the income of the assistance unit is equal to or less than LIFC 185% of the standard of need, income is then screened at the F&C 90% income limit, allowing income exclusions, when appropriate. Refer to M0710, Appendix 1 for LIFC 185% Standard of Need Chart.

Total gross income for this purpose includes all gross earned income, *other than Workforce Investment Act income and the income of a child under age 19 who is a student. It also includes* unearned income, such as net countable support, benefits, etc., and any income deemed available to the family/budget unit.

The following income is excluded when income is screened at 185%:

- a. All unearned income specifically excluded per M0730.099;
- b. For MED-UP, unemployment compensation benefits received by either parent.

If the countable income (gross income minus above exclusions) is equal to or less than LIFC 185% of the standard of need proceed to Step 2.

If the countable income is in excess of LIFC 185% standard of need, the FU/BU is not eligible as CNNMP. Determine if any members of the FU/BU would be eligible as MN.

**2. Step 2 -
90% Screen**

Once the total gross countable income of the family/budget unit is determined to be less than or equal to LIFC 185% standard of need, income must then be screened at the F&C 90% income limit. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for the F&C 90% income limits.

Total gross income includes all gross earned income, *other than Workforce Investment Act income and the income of a child under age 19 who is a student*. It also includes unearned income of all FU/BU members and any income deemed available to the family/budget unit. The following income is excluded when income is screened at 90%:

- a. All unearned income specifically excluded per M0730.099;
- b. Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the family/budget unit whose income is not otherwise exempt per M0720.520;
 - \$30 plus 1/3 exclusion and the \$30 monthly earned income exclusion if an FU/BU member received LIFC Medicaid in any one of the preceding four months per M0720.525 and M0720.526; and
 - child care/incapacitated adult care exclusion per M0720.540.

If the countable income (gross income minus above exclusions) is equal to or less than F&C 90% income limit, the individuals in the FU/BU that meet a CNNMP covered group are income eligible.

If the countable income is in excess of the F&C 90% income limit, the FU/BU is not eligible as CNNMP. Determine if any members of the FU/BU would be eligible as MN.

**D. VIEW
Participants**

VIEW participants' income eligibility in the LIFC covered group is determined by comparing all of the VIEW assistance unit's gross earned income, *other than Workforce Investment Act and income of a child under age 19 who is a student*, to the 100% Federal Poverty Limit (FPL) and unearned income to the F&C 90% income limit. If the earned income of the assistance unit is equal to or less than 100% of the FPL, then the unearned income is screened as the F&C 90% income limit for the locality. If the assistance unit's unearned countable income is equal to or less than the F&C 90% income limit, income eligibility for VIEW participants in the LIFC covered group is established.

If the VIEW assistance unit's earned or unearned income exceeds the limits, the assistance unit is not eligible as VIEW participants in the LIFC covered group. Determine if any family members are eligible as LIFC (non-VIEW) or in any other covered group.

**1. Step 1-
Earned
Income**

Determine the total gross earned income *other than Workforce Investment Act income and income of a child under age 19 who is a student*, of all required assistance unit members. Compare the total gross earned income to the 100% FPL Chart (see subchapter M0710, Appendix 6) for the income limit for the appropriate assistance unit size.

Total gross income for this purpose includes all gross earned income of both adults and children in the unit.

If the gross countable earned income is equal to or less than 100% FPL for the assistance unit, proceed to Step 2.

If the gross earned income is greater than 100% FPL for the assistance unit, the assistance unit is not eligible in the LIFC covered group. Determine if any family members are eligible in any other covered group.

**2. Step 2-
Unearned
Income**

Once the earned income is determined to be equal to or less than 100% FPL, unearned income must be screened at the F&C 90% income limit. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for the F&C 90% income limit.

Total unearned countable income includes all unearned income of all family unit members and any unearned income deemed available to the assistance unit. Exclude all unearned income in listed in M0730.099.

If the countable unearned income is equal to or less than the F&C 90% income limit, the individuals in the assistance unit meet the income requirements for the LIFC covered group and are eligible.

If the countable unearned income is greater than the F&C 90% income limit, the individuals in the assistance unit do not meet the income requirements for the LIFC covered group. Determine if any member of the assistance unit is eligible in any other covered group.

M0710.740 MEDICALLY NEEDED (MN)

The following procedures apply to the Medically Needed (MN) classification:

A. Locality Grouping and Income Limits

The countable income, allowing income exclusions when appropriate, is compared to the Medically Needed (MN) income limits for the locality and the number of members in the FU/BU.

Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the Medically Needed income limits.

B. Gross Income

Total gross income includes all gross earned *income, other than Workforce Investment Act income and income of a child under age 19 who is a student. It also includes the unearned income of all FU/BU members and any income deemed available to the family/budget unit.*

C. Excluded Income

The following income is excluded when income is compared to MN limits:

1. All unearned income specifically excluded per M0730.099;
2. Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the assistance unit whose income;
 - is not otherwise exempt per M0720.520;
 - child care/incapacitated adult care exclusion per M0720.540.

D. Income Eligibility

If the countable income (gross income minus above exclusions) is equal to or less than the appropriate MN limit for the locality and the number of members in the FU/BU, the FU/BU is income eligible as MN. If the countable income is in excess of the MN limit, the FU/BU must be placed on an MN spenddown following policy in chapter M13.

period. Income received in prior periods is normally used to determine the amount of income to be received in future periods. Income from the prior period is averaged and converted to a monthly amount. That monthly amount is the amount anticipated to be received in each of the future months. New sources of income may be anticipated based on statements from the provider of the income.

B. Definitions

1. Anticipated Income

Income the individual and local agency are reasonably certain will be received during the ongoing evaluation period.

To be reasonably certain that income will be received determine:

- from whom the income will come (the provider);
- in what month and on what dates it will be received (frequency and payment cycle); and
- how much will be received (rate).

2. Income Base Period

A period of time immediately prior to the month of application/redetermination that includes one or more pay periods, *or the most current equivalent (last 4 weekly pays, last 2 bi-weekly pays, or last 2 semi-monthly pays)* that is used to provide an accurate reflection of the individual's future income.

3. Monthly Income

Monthly income is the income received in an average month. An average month contains 4.3 weeks. Income received more frequently than monthly is converted to a monthly figure.

4. Pay Period

The time period covered by each pay check. A pay period may be weekly, bi-weekly, semi-monthly, monthly or longer periods of time.

C. Income Base Period Used

1. Non-Fluctuating Income

Use the income received in the month prior to the month of application/redetermination unless the prior calendar month cannot by itself provide an accurate indication of anticipated income.

2. Fluctuating Income

Use the income received in the month prior to the month of application/redetermination unless the prior calendar month cannot by itself provide an accurate indication of anticipated income.

When the prior calendar month cannot by itself provide an accurate indication of anticipated income use any number of pay periods immediately prior to application/redetermination that is still appropriate to the individual's circumstances. Select only the pay periods that will yield the most realistic estimate of income to be received. Document the file to support how the income was anticipated.

- 3. Seasonal Income** When the individual's income fluctuates seasonally, use the most recent season, past seasons, or the current calendar month prior to the month of application/redetermination, as an indicator of future income.
- Use the information obtained from the income provider and worker judgement to determine the anticipated income. Document the file to support how the income was anticipated.
- 4. Migrant Or Seasonal Farm Worker** For migrant and seasonal farm workers, the income that is reasonably certain to be received is based on formal or informal commitments for work for an individual, rather than on the general availability of work in an area.
- Base income on the information obtained from the income provider and worker judgement to determine the anticipated income. Document the file to support how the income was anticipated.
- Do not base income on an assumption of optimum weather or field conditions.
- 5. New or Increased Income** Use the income provider's statement of the beginning date, the amount of income to be received, the frequency of receipt, and the day/dates of receipt to establish the amount to be received per pay period.
- 6. Terminated Income** *Income from a terminated source must only be verified when it was received in a month in which eligibility is being determined.*
- 7. Decreased Income** Use the income provider's statement of the beginning date of the decrease, the new amount of income to be received, the frequency of receipt, and the day/date of receipt to establish the amount to be received per income period. Document the file to support how the income was anticipated.
- If an employed person anticipates a decrease in wages that is not supported by evidence in the file, the individual must be advised to report the decrease as soon as it can be verified. Adjustments are made when the decrease is verified.

D. Calculating Estimated Monthly Income

- 1. Full Month's Income** Total the income received in the Income Base Period. Divide that total by the number of pay periods in the Income Base Period. The result is the average amount to be received per pay period. If the income is received more frequently than monthly, convert the income to a monthly amount.

M1340.000 SPENDDOWN DEDUCTIONS**M1340.100 SPENDDOWN DEDUCTIONS****A. Introduction**

Medical expenses incurred by the individual, family or a financially responsible relative that are not subject to payment by a third party are deducted from the individual's spenddown liability. An expense is incurred on the date liability for the expense arises. The agency must determine which incurred expenses can be deducted and must deduct those expenses in accordance with section M1340.200 below.

The policy and procedures for deducting old bills and incurred expenses are based on federal regulations which were developed to remove the incentive for individuals to not pay their old bills.

B. Policy

Only those medical, dental, or remedial care expenses incurred by the applicant, budget unit member(s) and the applicant's spouse and/or child in the household who is not included in the applicant's assistance unit, are considered as potential deductions from spenddown.

1. Legal Liability For Expense

Medical expenses, or portions of medical expenses, that are covered by Medicare or other health insurance are not legal obligations of the individual and cannot be deducted from spenddown. If the expense was covered by a state or local public program as defined in section M1340.1100, see that section.

If a legally responsible relative's income is deemed to the assistance unit, the legally responsible relative's incurred expenses are deducted from the unit's spenddown. When the legally responsible relative also has a spenddown liability that has not been met, the legally responsible relative must choose the spenddown from which the incurred expense is deducted. An incurred expense can be deducted from only one spenddown. If not totally used to meet the spenddown, the balance can be applied to another spenddown.

2. Projected Expenses

"Projected" expenses are for services that have not yet been rendered. Projected expenses for medical services cannot be deducted, except for nursing facility care. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered. See subchapter M1460 or M1480 for nursing facility patients.

3. Chronological Deduction

Expenses are deducted in chronological order based on the date they are incurred. The date incurred is the date the service was received or, in the case of health insurance premiums *that are withheld from monthly benefit payments, the first day of the month the premium payment is due.*

4. Multiple Spenddown Periods

When an individual has established more than one spenddown period, medical expenses are first deducted from the spenddown period during which they were incurred. If not used to achieve eligibility, the bill can be evaluated for use in succeeding budget periods. Specific instructions for treatment of prior

incurred expenses can be found in sections M1340.600, M1340.700 and M1340.800.

M1340.200 KINDS OF ALLOWABLE DEDUCTIONS

- A. Policy** To determine the allowable incurred expenses that will be deducted from income, the agency must identify the kind of service.
- B. Kinds of Service** In determining allowable incurred expenses, the medical or remedial care expenses listed below may be deducted from the spenddown liability.
- 1. Health Insurance Expenses** Medicare and other health insurance premiums are allowable health insurance expenses.
 - 2. Noncovered Services Expenses** Noncovered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan. Noncovered services include expenses for Medicaid-covered services that exceed the State Plan limits on the amount, duration and scope of services. Medicaid co-payments and deductibles on covered services are “noncovered services.” Section M1340.400 lists noncovered services.
 - 3. Covered Services Expenses** Covered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

M1340.300 HEALTH INSURANCE PREMIUMS, DEDUCTIBLES, COINSURANCE

- A. Policy** Incurred expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including deductibles and copayments imposed by Medicaid, are deducted from the spenddown liability.
- B. Health Insurance Premiums** Health insurance premium payments include:
- 1. Private Health Insurance** Payments made from the applicant’s own income for private medical insurance are allowed deductions. Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the spenddown liability.
 - 2. Medicare Premiums** Medicare Part A and/or Part B premium payments are allowed deductions when the premiums are paid from the applicant’s own income.
 - 3. Amount Deducted** The amount deducted is the amount of the premium paid.

- 4. When Deducted** A health insurance premium is deducted from the spenddown liability *when the monthly premium is due*. The worker cannot deduct a pre-paid premium that is paid before the *month the premium is due*.
- When a health insurance premium is *withheld* from the individual's *monthly benefit* check, the *premium is deducted on the first day of the month*. For example, the individual receives a Social Security benefit from which is deducted the Medicare Part B premium. The Social Security check is dated December 13. The Medicare Part B premium is deducted from the individual's spenddown liability on December 1.
- C. Deductibles, Coinsurance, and Copayments**
- Deductibles, coinsurance and co-payment amounts are those portions of a medical services expense which the health insurance policy designates as the individual's responsibility to pay. The health insurance policy will not pay these amounts.
- 1. Amount Deducted** The amount deducted is the amount of the deductible, coinsurance or co-payment owed for the service.
- 2. When Deducted** A deductible, coinsurance or co-payment amount is deducted from the spenddown liability on the date the service was received.
- D. Verification** Verification of health insurance premiums, deductibles, coinsurance and copayment amounts include:
- a copy of the insurance premium notice,
 - the explanation of benefits paid by health insurance,
 - Medicaid co-pays and deductibles as listed in chapter M18, or the Virginia Medicaid Handbook.

M1340.400 NONCOVERED SERVICES

- A. Policy** Noncovered services expenses are incurred expenses for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan, including the amounts for covered services that exceed the State Plan limits on amount, duration and scope of services. Noncovered services must be ordered by a physician or dentist in order to be deducted.
- Noncovered services expenses are deducted on the date the service was rendered. For medical supplies and equipment that are ordered, the date of service is the date the supply or equipment was delivered to the individual. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered.

B. Noncovered Services

Noncovered services (not covered by Medicaid) include:

1. routine dental care for individuals age 21 or older.
2. services of other licensed practitioners of the healing arts such as chiropractors, naturopaths or acupuncturists, unless the services are covered by Medicare and the individual has Medicare.
3. professional nursing services in an individual's home when prescribed by the individual's physician and the cost is not part of a home health program or a Medicaid CBC waiver.
4. medical services provided by non-participating providers (providers who do not participate in Virginia Medicaid) unless the services are covered by Medicare and the individual has Medicare.
5. over-the-counter medications and medical supplies when ordered by a physician and the cost is not covered by Medicaid or Medicare, if the individual has Medicare.

C. Not Medical/ Remedial Care Services

The following are examples of services that are NOT medical/remedial care services and CANNOT be deducted from a spenddown liability, even if ordered by a physician:

- air conditioners or humidifiers,
- Adult Care Residence (ACR) room & board and services,
- personal comfort items, such as reclining chairs or special pillows,
- health club memberships and costs,
- animal expenses such as for seeing eye dogs,
- cosmetic procedures.

D. Verification

Verification of noncovered services expenses includes:

1. a copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
 - the amount still owed that is the patient's responsibility, and
 - the service provider's name, address, and profession.
2. a prescription, physician's referral, or statement from the patient's physician or dentist that the service was medically necessary.

M1340.500 COVERED SERVICES**A. Policy**

Covered services expenses are incurred expenses for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

- Peninsula AIDS Foundation
- Northern Virginia AIDS Project
- INOVA System/Office of HIV
- Council of Community Services
- AIDS Support Group, Inc.
- Whitman Walker Clinic of Northern Virginia

5. Consumer-Directed Personal Attendant Services (CDPAS) Waiver

Local and hospital screening committees or teams screen individuals for the CDPAS waiver. *The final authorization for the CDPAS waiver is made by DMAS or WVMI, a DMAS contractor.*

6. Individual and Family Developmental Disabilities Support (DD) Waiver

DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure the eligibility determination process takes place simultaneously with screening decisions so that nursing facility placement or receipt of CBC services may be arranged as quickly as possible, prompt communication between screeners and eligibility staff must occur.

Each agency shall designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital social services staff, and DRS staff shall be given instructions on how to contact that person.

B. Procedures

1. Screeners

Screeners must inform the agency eligibility worker that the screening process has been initiated.

2. EW Action

The eligibility worker must begin to process the individual's Medicaid application when informed that the screening process has begun.

3. Provider Involvement

If the individual is found eligible and verbal assurance of approval by the screening committee has been received, the EW must provide, without delay, the facility or CBC provider with the recipient's Medicaid ID number.

4. Designated DSS Contact

The local DSS agency should designate an appropriate eligibility staff member for screeners to contact. Local social services staff,

hospital social services staff and DRS staff should be given the name of, and instructions on how to contact, that person. This will facilitate timely communication between screeners and the eligibility determination staff.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes a local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals and verifies qualification for special personal maintenance allowances for temporary stays in long-term care facilities. The screening certification is valid for one year.

B. Procedures

1. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application or has been a patient in a nursing facility for at least 30 consecutive days;
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility *directly from the E&D or CDPAS waiver*;
- *the individual leaves a nursing facility and begins receiving E&D or CDPAS waiver services; or*
- the individual enters a nursing facility from out-of-state.

2. Documentation

a. If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record.

b. Substantiation is by:

- a DMAS-96 (see Appendix 1);
- a MR Waiver Level of Care Eligibility Form (see Appendix 2);
- a DD Waiver Level of Care Eligibility Form (see Appendix 3); or
- a CDPAS Authorization Form (see Appendix 4).

c. The screening certification is valid for one year.

3. DMAS-96

For an individual who has been screened and approved for the E&D, Technology-Assisted, or AIDS waiver, the DMAS-96 "Medicaid Funded Long-term Care Pre-admission Screening Authorization" form will be signed and dated by the screener. The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under "Nursing Home Pre-admission Screening." These numbers denote approval of Medicaid payment for a waiver service. See Appendix 1 for a copy of the DMAS-96.

- f. Assiniboine Tribe of Fort Peck Montana [ref. P.L. 98-124]
- g. Assiniboine Tribe of Port Belknap [ref. P.L. 98-124]
- h. Shoshone and Arapaho Tribes of Wind River Reservation of Wyoming [ref. P.L. 98-64].

21. Indian Trust or Restricted Land Payments

Income from individual interests in Indian Trust or Restricted Lands up to \$2,000 per year in payments is excluded [ref. P.L. 103-66].

22. Walker v. Bayer Settlement Payments

The following payments from the settlement of the Walker v. Bayer Corp., et.al., lawsuit (sometimes called the “Hemophilia Litigation Settlement”) are excluded as income: [ref. P.L.105-33].

- a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., or
- b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of
 - December 31, 1997, or
 - the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

The **interest** received on these excluded funds is NOT excluded and must be counted as income in the month received.

23. Home Produce

Home produce consumed by the individual or his household is excluded as income. Proceeds from the sale of home produce ARE counted as earned or unearned income [ref. 1612(b)(8)].

C. What Is NOT Income For All Covered Groups EXCEPT F&C MN

The items below are NOT income when determining eligibility for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

1. Specific VA Payments

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

- a. *Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.*

NOTE: *This applies to patients in nursing facilities, including the Veterans Care Center in Roanoke, Va.*

- b. Payments for unusual medical expenses.
- c. Payments made as part of a VA program of vocational rehabilitation.
- d. VA clothing allowance.
- e. Any pension paid to a nursing facility patient who is
 - a veteran with no dependents, or
 - a veteran's surviving spouse who has no child.

NOTE: *Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to patients in nursing facilities, including the Veteran's Care Center in Roanoke, Va.*

- f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

- a. Seneca Nation Settlement Act [ref. P.L. 101-503]
- b. Yakima Indian Nation [ref. P.L. 99-433]
- c. Papago Tribe of Arizona [ref. P.L. 97-408]
- d. Shawnee Indians [ref. P.L. 97-372]

M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

- A. Introduction** This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. This post-eligibility treatment of income is called **patient pay**.
- B. Policy** The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, ICF-MR or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services.
- The DMAS-122 form shows the provider how much of the cost of care is paid by the patient (patient pay). The provider collects the patient pay from the patient or his authorized representative.
- The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not affect the patient's Medicaid eligibility. However, if the patient pay is not paid to or collected by the provider, the EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.
- C. Patient Pay Definition** "Patient pay" is the amount of the LTC patient's income which must be paid as his share of the LTC services cost. This amount is shown on the DMAS-122 to the provider and on the "Notice of Obligation for Long-Term Care Costs" to the patient.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

- A. Gross Income** Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.
- 1. 300% SSI Group** If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in C. below.
 - 2. Groups Other Than 300% SSI Group** If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

- B. Income Counted For Patient Pay** All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in subsection C. below is counted as income for patient pay.
- 1. Aid & Attendance and VA Pension Payments** *The total VA Aid & Attendance payments and/or VA pension payments in excess of \$90.00 per month must be counted as income for patient pay when the patient is:*
- a veteran who does not have a spouse or dependent child, or
 - a deceased veteran's surviving spouse who does not have a dependent child.
- NOTE: This applies to patients in nursing facilities, including the Veterans Care Center in Roanoke, Va.*
- 2. Advance Payments To LTC Providers** Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay.
- Advance payments which will not be refunded are usually made to reduce the recipient's resources to the Medicaid limit.
- C. Income Excluded As Patient Pay Income** All income listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans *which are counted in the patient pay calculation (see B. above)*. Other types of income excluded from patient pay are listed below.
- 1. SSI Payments** All SSI payments are excluded from income when determining patient pay.
- 2. Certain Interest Income**
- a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.
- b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to \$10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.
- Verify interest income at application and each scheduled redetermination.
 - If average interest income per month exceeds \$10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.
- 3. Repayments** Amounts withheld from monthly benefit payments to repay prior overpayments are not income for patient pay (the patient or his representative should be advised to appeal the withholding).

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

- A. Entitlement After Spenddown Met** When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.
- B. Procedures**
- 1. Coverage Dates** Coverage begin date is the first day of the month; the coverage end date is the last day of the month.
 - 2. Program Designation**
 - a. If the institutionalized spouse does NOT have Medicare Part A:**
 - Aged = **18**
 - Blind = **38**
 - Disabled = **58**
 - Child Under 21 in ICF/ICF-MR = **98**
 - Child Under Age 18 = **88**
 - Juvenile Justice Child = **85**
 - Foster Care/Adoption Assistance Child = **86**
 - Pregnant Woman = **97**
 - b. If the institutionalized spouse has Medicare Part A:**

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):

 - 1) When income is less than or equal to the QMB limit, enroll using the following PDs:
 - Aged = **28**
 - Blind = **48**
 - Disabled = **68**
 - 2) When income is greater than the QMB limit, enroll using the following PDs:
 - Aged = **18**
 - Blind = **38**
 - Disabled = **58**
 - 3. Patient Pay** Determine patient pay according to section M1480.400 below.
 - 4. Notices & Re-applications** The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, NO amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- B. Monthly Maintenance Needs Standard**

<i>\$1,515.00</i>	<i>7-1-03</i>	
\$1,492.50	7-01-02	
- C. Monthly Maintenance Needs Allowance Maximum**

<i>\$2,266.50</i>	<i>1-1-03</i>	
\$2,232	1-1-02	
- D. Excess Shelter Standard**

<i>\$454.50</i>	<i>7-1-03</i>	
\$447.75	7-1-02	
- E. Utility Standard Deduction (Food Stamps Program)**

\$194	1 - 3 household members	10-1-02
\$240	4 or more household members	10-1-02
\$202	1 - 3 household members	10-1-01
\$252	4 or more household members	10-1-01

M1480.420 PATIENT PAY FOR ABD 80% FPL and 300% SSI INSTITUTIONALIZED SPOUSE

- A. Policy** After an ABD 80% FPL or a 300% SSI institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

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M1510.000 MEDICAID ENTITLEMENT

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**1. Excess
Income In
One or More
Retroactive
Months**

When an applicant has excess income in one or more of the retroactive months, he must verify that he met the nonfinancial and resource requirements in the month(s). He must verify the income he received in **all 3** retroactive months in order to determine his MN income or spenddown eligibility in the retroactive month(s).

If he fails to verify income in all three months, he CANNOT be eligible as medically needy in the retroactive period. His application for the retroactive months in which excess income existed must be denied because of failure to provide income verification for that month(s). However, coverage for the retroactive month(s) in which he was eligible as CNNMP or MI must be approved.

EXAMPLE #2: (Using July 2003 figures)

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March. She also has unpaid medical bills (*old bills*) from December. The retroactive period is January - March.

The eligibility worker determines that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that the countable income of \$3,250 per month in January and February exceeded the F&C MI and the MN income limits. The income of \$800 starting March 1 is within the F&C MI income limit. The parent verifies that the resources in January and February were within the MN resource limit, but does not verify the March resources because the income is within the MI income limits.

The application is approved for retroactive coverage as MI beginning March 1 and for ongoing coverage beginning April 1. The child's spenddown liability is calculated for January and February. The eligibility worker deducts the old bills and the incurred medical expenses, and a spenddown liability remains. The retroactive coverage is denied for January and February.

**2. Excess
Income In All
3 Retroactive
Months**

When excess income existed in all classifications in all 3 retroactive months, the applicant must verify that he met all eligibility requirements in all 3 months. If he fails to verify nonfinancial, resource or income eligibility in any of the retroactive months, the retroactive period cannot be shortened and he CANNOT be placed on a retroactive spenddown. His application for retroactive coverage must be denied because of excess income and failure to provide eligibility verification for the retroactive period.

EXAMPLE #3: (Using July 2003 figures)

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March. The retroactive period is January - March.

The worker verifies that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that their countable income of \$3,250 in January, February and March exceeded the F&C MI and the

MN income limits. The worker verifies that their resources in January and February were within the MN resource limit, but is unable to verify the resources for March.

The application is denied for retroactive coverage as MI because of excess income and denied for MN because of failure to provide resource verification for the retroactive period.

E. Disabled Applicants

If the applicant was not eligible for SS or SSI disability benefits during the retroactive period and the recipient alleges he/she was disabled during the retroactive period, follow the procedures in M0310.112 for obtaining an earlier disability onset date.

F. Excess Resources in Retroactive Period

If the applicant had excess resources during part of the retroactive period, retroactive resource eligibility exists only in the month(s) during which the resources were at or below the limit at any time within the month. The applicant's eligibility must be denied for the month(s) during which excess resources existed during the entire month.

EXAMPLE #4: (Using July 2003 figures)

Mr. A 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 currently receives SS disability benefits of \$1500 per month and received SS disability of \$1500 monthly during the retroactive period. He is not eligible for Medicare Part A. His verified resources exceeded the MN limit in April and part of May; the resources were reduced to below the MN limit on May 20. He met the retroactive spenddown on April 5. His application was approved for retroactive MN coverage beginning May 1, and April coverage was denied because of excess resources.

G. Income Determination

Countable income for the applicant's unit is that income which was actually received in the three months prior to the application month.

1. Monthly Determination for CN/CNNMP & MI

When an individual in the family unit meets a CN, CNNMP or MI covered group, compare each month's countable income to the appropriate CN/CNNMP or MI income limit for the month. When the countable income is within the CN, CNNMP or MI income limit in the month, the CN, CNNMP or MI individual meets the income eligibility requirement for that retroactive month. Enroll the eligible CN, CNNMP or MI unit member(s)

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. MI Pregnant Woman

For an eligible medically indigent pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

2. Spenddown Recipients

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application.

An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the *DDS* or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for *SS/SSI* and Medicaid as disabled, and *DDS* denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures**1. Subsequent
SSA/SSI
Disability
Decisions**

The SSA disability decision takes precedence over a *DDS* decision (*DDS* will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and *re-evaluate the denied Medicaid application*. *If the re-evaluation determines that the individual is eligible, entitlement is based on the date of the Medicaid application and the disability onset date. If the denied application is more than 12 months old, a redetermination using current information must also be completed.*

M1510.104 FOSTER CARE CHILDREN**A. Policy**

Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

**B. Retroactive
Entitlement**

If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another *covered group* and all other Medicaid eligibility requirements in the retroactive period. *If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.*

M1510.105 DELAYED CLAIMS**A. When Applicable**

Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the

If the individual is not eligible because of income, send an advance notice and cancel the individual's Medicaid coverage because of excess income, and place the individual on a medically needy spenddown.

**C. Medically Needy
(MN)**

The Medicaid eligibility of all MN covered groups must be redetermined at least once every 12 months UNLESS the individual or family became eligible by meeting a spenddown. The twelve-month review period begins with the month of application for Medicaid. Use the Eligibility Review Part A and the Eligibility Review Part B forms or an ADAPT Statement of Facts for the redetermination.

Spenddown cases are not subject to review. Instead, a new application must be filed following the end of the spenddown period.

Review the recipient's SSN, program designation and TPL information in the MMIS to assure that they are correct.

D. Medically Indigent

Review the recipient's SSN, program designation and TPL information in the MMIS to assure that they are correct.

**1. Pregnant
Woman**

Do not redetermine the eligibility of an MI pregnant woman until the 60-day period after pregnancy ends. During the 60-day postpartum period, a complete Medicaid redetermination must be completed to determine if eligibility can be established in another covered group. The Eligibility Review Part A and the Eligibility Review Part B forms can be used if the initial eligibility was determined using an Application for Benefits and no additional nonfinancial information is needed. If initial eligibility was determined using the MI application or additional nonfinancial information is needed, the Application for Benefits or an ADAPT interactive interview can be used to obtain the information necessary to evaluate eligibility.

If she is eligible in a full-benefit covered group change her PD in the MMIS. If she is eligible in the limited-benefit Family Planning Services covered group, send the advance notice of the reduction in benefits and cancel her full coverage at the end of month in which the 60-day postpartum period or the advance notice period ends, whichever comes later. Do not use change transactions to move an individual between full and limited coverage. Reinstate the Family Planning Services limited coverage in the MMIS the month following the month full coverage was cancelled.

If she is not eligible because of income and she meets an MN covered group, send an advance notice and cancel her Medicaid coverage because of excess income, and place her on a medically needy spenddown.

If the woman does not meet a definition for another covered group, cancel her Medicaid coverage because she does not meet a Medicaid covered group.

**2. Newborn
Child Turns
Age 1**

A redetermination must be done when a newborn child turns age 1 and must include:

- a. evaluation of the child's eligibility in another covered group and completion and signing of the appropriate application (Children's Health Insurance in Virginia, the Eligibility Review Part A and the Eligibility Review Part B, or the ADAPT Statement of Facts);
- b. SSN or proof of application, and the Assignment of Rights form;
- c. for an MI child, a review of income;
- d. for an MN child, a review of income and resources.

**3. MI Child
Under Age 19**

The Medicaid eligibility of children in the MI Child Under Age 19 covered group must be redetermined at least once every twelve months. The twelve-month review period begins with the month of application for Medicaid. The Children's Health Insurance in Virginia application, the ADAPT Statement of Facts, or other appropriate forms can be used for the redetermination.

*When an enrolled MI child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send an Advance Notice of Proposed Action to the family to cancel the child's Medicaid coverage effective the last day of the month in which the 10-day advance notice expires and enroll him in FAMIS effective the first day of the month following the Medicaid cancellation. **Do not use change transactions to move a child between Medicaid and FAMIS.** If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an Advance Notice of Proposed Action and canceling the child's Medicaid coverage.*

**4. MI Child
Turns Age 19**

When an MI child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.

If the child meets a covered group, obtain the information about the family's resources and income on the Eligibility Review Part A and the Eligibility Review Part B forms or through an ADAPT interactive interview to determine if the child's resources and income are within the applicable limits for the child's covered group. If the child is eligible in another covered group, change the child's PD in the MMIS. If the child

M1520.500 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid recipients may be eligible for an extended period of Medicaid coverage when the family *meets all the requirements for* the Low Income Families with Children (LIFC) covered group *except income*.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to increased income from child and/or spousal support may be eligible for a 4-month extension.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a 12 months extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.501 below.

The policy and procedures for the twelve-month extension are in section M1520.502 below.

M1520.501 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The family lost eligibility solely or partly due to receipt of or Increased child or spousal support income; and
- All other Medicaid eligibility factors except income are met.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family unit who received Medicaid, erroneously during 3 or more of the 6 months preceding the month of ineligibility does not qualify for the Medicaid extension.

- 2. New Family Member**

A new member of the family unit is eligible for Medicaid under this provision if he/she was a member of the unit in the month the unit became ineligible for LIFC Medicaid. However, even if a baby was not born as of that month, a baby born to an eligible member of the unit during the 4-month extension is eligible under this provision because the baby meets the categorically needy non-money payment newborn child under age 1 covered group.
- 3. Moves Out of State**

Eligibility does not continue for any member of the family unit who moves to another state.
- 4. Coverage Period**

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of support income.
- 5. Program Designation**

Cases eligible for this four-month extension are categorically needy non-money payment. A Medicaid-Only application and case are recorded statistically. The program designation for the recipients in the unit remains "81" or "83."
- 6. Case Handling**

Those cases closed in a timely manner must be held in a suspense file until the fourth month after the LIFC Medicaid cancellation month. At that time, action must be taken to evaluate continuing Medicaid eligibility.

If all eligibility factors are met, the children in the case may continue eligible as MI or medically needy. Make the appropriate program designation changes to the computer file.

The caretaker's Medicaid coverage must be canceled if he/she does not meet a Medicaid covered group. An appropriate "Advance Notice of Proposed Action", form 032-03-018 must be sent to the recipient if the caretaker or the case is no longer eligible for Medicaid.

M1520.502 TWELVE-MONTHS EXTENSION

A. Policy

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met.

The family consists of those individuals living in the household whose needs and income were included in determining the LIFC Medicaid eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.

The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for the extension, no action is required until the ninth month of extension, except to be sure that the indicator code was updated in the computer when the income report was received.

6. Ninth Month of Extension

In the ninth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" with earnings and child care cost verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

The Medicaid computer will automatically send this notice if the correct indicator code is in the base case information on the computer. If it is not, the local agency must manually send this notice.

7. Tenth Month of Extension

If the third three-month period's report and verifications are not received by the 21st of the tenth month, the family's Medicaid coverage must be canceled after an advance notice is sent. The Medicaid computer will automatically cancel coverage and send the advance notice if the report is not received on time and the indicator code is not changed. Medicaid coverage must be canceled unless the family establishes good cause for failure to report timely (see 5. above for good cause).

a. Determine Child(ren)'s Eligibility

If the report is not received on time, the child(ren)'s eligibility for Medicaid under another covered group must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, and resources. If eligible, change the child(ren)'s enrollment to the appropriate program designation before the **cut-off date** of the eleventh extension month. If not eligible, leave the child's enrollment (and the base case special review field) as it is and the computer will cancel the child(ren)'s coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eleventh extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child(ren) is found eligible.

b. Cancellation Effective Date

Cancellation is effective the last day of the eleventh month of extension.

c. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, change the base case indicator code in the Medicaid computer immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in 5.c. above applies. Calculate the family's income using the procedures in 5.d. above.

d. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to **extended** Medicaid coverage, review their eligibility for Medicaid under another category and/or classification. If not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension.

If the family is ineligible because of excess income and all other eligibility factors are met, cancel Medicaid and place the family members who meet a medically needy covered group on spenddown. **Send the Advance Notice of Proposed Action.**

e. Family Remains Entitled To Extended Medicaid

If the family remains entitled to extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination.

The Medicaid computer will automatically cancel coverage and send the advance notice after cut-off of the twelfth month, if the indicator code was updated correctly. Therefore, for any of the family members that remain eligible, the PD (if applicable) and the indicator code must be changed before cut-off of the twelfth month.

If all eligibility factors are met except income, place the family members who meet a medically needy covered group on spenddown. **Send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month. The spenddown period begins the first day of the following month.

M1520.503 TRANSITIONAL MEDICAID BENEFITS

The Transitional Medicaid extension expired June 30, 2003 and was only applicable to VIEW participants who did not qualify for the Twelve-Month extension.

M1520.600 CASE TRANSFERS

- A. Introduction** Applications and ongoing cases are transferred only when the individual retains residence in Virginia.
- B. Nursing Facility and Assisted Living Facility (ALF)** When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.
- When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.
- C. DMHMRSAS Facilities** The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from DMHMRSAS facilities are in subchapter M1550. F&C cases are not transferred.
- D. DMAS Medicaid Unit-FIPS 976** The Medicaid cases approved by the DMAS Medicaid unit, FIPS 976, must be transferred to the local agency where the recipient lives. The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the DMAS Medicaid unit. Cases from the DMAS Medicaid unit do not require a redetermination until the annual redetermination is due.
- Medicaid cases are not transferred from local agencies to FIPS 976.
- E. Locality to Locality** When a Medicaid applicant/recipient (including a Medicaid CBC waiver services recipient) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or a group home with 4 or more beds) in another locality within the State of Virginia, the following procedures apply:
- 1. Sending Locality Responsibilities** The sending locality (the locality from which the recipient has moved) must review the case immediately and make an evaluation, based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality.
- If the desk review finds that eligibility no longer exists, the agency must take the necessary action, including advance notice to the individual, to cancel coverage and to cancel the case in the MMIS.
- If the desk review indicates that the recipient will continue to be eligible for Medicaid in the new locality, the sending locality must update the MMIS

with the new address and city/county code so that the new locality can accept the case for transfer. The superintendent/director of the transferring locality must prepare the form "Case Record Transfer Form" and forward it, with the case record, to the department of social services in the new locality of residence.

Pending applications must be transferred to the new locality for an eligibility determination.

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or at the agency's discretion the case may be sent via the courier pouch.

**2. Receiving
Locality
Responsibilities**

The receiving agency (the DSS agency in the locality to which the recipient moves) must *redetermine* the recipient's circumstances in his new locality. The agency must *redetermine* the recipient's eligibility as soon as administratively feasible, but no later than the second month after the month in which a transfer request is received. *The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.*

If the eligibility redetermination by the receiving agency finds that eligibility no longer exists, that agency must take the necessary action, including *sending* advance notice to cancel coverage and canceling the case in the MMIS.

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in the MMIS.

F. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

**1. Sending
Locality
Responsibilities**

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- *deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;*
- note the spenddown period and balance on the case transfer form.

**2. Receiving
Locality
Responsibilities**

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. There is no retroactive coverage in FAMIS. Case management and ongoing case maintenance, and selection for managed care are handled by the FAMIS CPU.

B. Legal Base

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for Medicaid due to excess income;
- he is under age 19 and a resident of Virginia;
- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency or a local governmental agency that participates in the Local Choice Program and contributes to the cost of dependent health insurance (see Appendix 2 and Appendix 3 to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 6 months of the application without good cause *for months prior to August 1, 2003, and within 4 months for months on or after August 1, 2003*;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and full benefit alienage requirements (no grandfathered aliens);
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

5. Insured means having creditable health insurance coverage or coverage under a health benefit plan.

6. Uninsured means having no insurance; having insurance that is not creditable; or having coverage which is not defined as a health benefit plan.

C. Policy A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot**:

- have creditable health insurance coverage;
- have coverage under a group health plan (Medicare Part A or B, CHAMPUS, federal employee benefit plan, private group insurance such as Trigon, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to this chapter];
- be a member of a family eligible for health benefits coverage on the basis of a family member's employment with a public agency in the State that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance (see Appendix 2 to this chapter), or
- *without good cause, have had creditable health insurance coverage terminated within a designated period of time prior to the month for which eligibility is being established. The designated period of time is 6 months prior to August 2003, and is 4 months for August 2003 and forward.*

Good cause reasons are listed in E. below.

**D. Health
Insurance
Coverage
Discontinued**

A child is ineligible for FAMIS coverage if his creditable health insurance coverage was terminated without good cause within a designated period of time prior to the month for which eligibility is being established. The designated period of time is 6 months prior to August 2003 and is 4 months for August 2003 and forward.

***Example:** A child's health insurance was terminated without good cause March 2003. A FAMIS application was filed in July 2003. The child is ineligible for July because his health insurance was terminated within 6 months prior to July. He could be eligible for August as the insurance was terminated more than 4 months prior to August.*

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

**E. Good Cause for
Dropping Health
Insurance**

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative with whom the child lives may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency will determine that good cause exists and waive the *period of ineligibility* if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g. the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the premium exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

cost the State any more than it would cost to cover the children in FAMIS. Children enrolled in FAMIS whose families have access to ESHI coverage may qualify to have the State pay part of the family's share of the health insurance premium as long as all of the following conditions are met:

- the employer must pay at least 40% of the cost of the family health insurance
- the cost of covering the child under the employer-sponsored health insurance (ESHI) plan has to be less than or equal to the cost of covering the child under FAMIS
- the family must apply for the full premium contribution from the employer.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the child has access to employer sponsored health insurance (ESHI). Families who have access to ESHI will receive information from the DMAS about the benefits of enrolling in the ESHI component of FAMIS and information about how to participate in the program. Participation in the FAMIS ESHI component is voluntary.

***F. 12-Month
Continuous
Coverage***

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.