



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

October 31, 2003

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #75

The following acronyms are used in this transmittal:

- ABD - Aged, Blind or Disabled
- CDPAS - Consumer Directed Personal Assistance Services
- DMAS - Department of Medical Assistance Services
- F&C - Families and Children
- FAMIS - Family Access to Medical Insurance Security Plan
- FPS - Family Planning Services
- LDSS - Local Departments of Social Services
- LIFC - Low Income Families With Children
- LTC - Long-term Care
- MI - Medically Indigent
- MN - Medically Needy
- QDRO - Qualified Domestic Relations Order
- VIEW - Virginia Initiative for Employment not Welfare

This transmittal contains the following changes to policy, effective December 1, 2003 except where otherwise noted:

- LDSS may now certify routine labor and delivery for Emergency Services Aliens who receive pregnancy-related services.
- The definition of a VIEW participant used to allow enhanced earned income disregards has been added.
- Women in the MI Pregnant Women covered group are automatically eligible for the FPS covered group.
- The resource test for most F&C categorically needy covered groups has been eliminated.

- The QDRO has been added as an exception to the unearned income policy for the ABD covered groups.
- The competency and age requirements for the CDPAS waiver have been eliminated.

The amount allowed by DMAS for LTC patient pay medical expense deductions that exceed \$500 is limited to the prevailing Medicare or Medicaid rate. This change was previously released in Broadcast 2275, posted on August 4, 2003.

This transmittal also contains clarification of the vehicle exclusion policy for F&C MN and ABD eligibility determinations. This clarification was previously released in Broadcast 2190, posted on June 16, 2003.

The Application for Benefits and the Application for Children's Health Insurance in Virginia are updated in this transmittal. In addition, the utility standard used for LTC patient pay calculations is updated effective October 1, 2003.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0120 Appendix 3 Appendix 6	Subchapter M0120 Appendix 3 Appendix 6	Updated Appendix 3, the Application for Benefits and Appendix 6, the Application for Children's Health Insurance in Virginia.
Subchapter M0220 Table of Contents pages 21-25	Subchapter M0220 Table of Contents pages 21-24	Updated the Table of Contents. On pages 21 and 22, added policy and procedures for LDSS certification of routine pregnancy-related labor and delivery services for Emergency Services Aliens. Page 22a and 24 are runover pages. On page 23, clarified emergency services entitlement/enrollment policy and added the citizenship code used to enroll Emergency Services Aliens on dialysis.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
<p>Subchapter M0310 Table of Contents pages 15-20 pages 29-32 page 39</p>	<p>Subchapter M0310 Table of Contents pages 15-20 pages 29-32 page 39</p>	<p>Updated the Table of Contents. Page 15 is a reprint. On pages 16-19, deleted resources in the eligibility determination. Pages 20 and 29 are reprints. On pages 30 and 31, deleted resources in the eligibility determination. Page 32 is a reprint. On page 39, added the definition for a VIEW participant.</p>
<p>Subchapter M0320 pages 45, 46 pages 49-50b pages 53, 54 pages 57-60</p>	<p>Subchapter M0320 pages 45, 46 pages 49-50c pages 53, 54 pages 57-60</p>	<p>Page 45 is a reprint. On page 46, updated the list of covered groups. On pages 49-50a, revised the policy and procedures for eligibility/enrollment in the FPS covered group. On pages 50a and 50b, clarified the period of entitlement for the MI Child Under Age 19 (FAMIS Plus) covered group. Page 50c is a runover page. On page 53, deleted the resource test for the LIFC covered group. Page 54 is a reprint. On page 57, deleted the resource test for the Individuals Under Age 21 covered group. Pages 58 and 60 are reprints. On page 59, deleted the resource test for the Special Medical Needs Adoption Assistance Children covered group.</p>
<p>Subchapter M0330 pages 17, 18</p>	<p>Subchapter M0330 pages 17, 18</p>	<p>Page 17 is a reprint. On page 18, revised reference for spenddown policy.</p>
<p>Subchapter M0520 pages 5-22 pages 27-32 pages 35-39</p>	<p>Subchapter M0520 pages 5-22 pages 27-32 pages 35-38</p>	<p>On pages 5-18, clarified text for family/budget units and eliminated resources for LIFC. Page 19 is a reprint. On pages 20-22, clarified text for family/</p>

Remove and Destroy Pages

Insert Attached Pages

Significant Changes

		<p>budget units. On page 27, updated reference to MI child covered group. Page 28 is a reprint. On pages 29 and 31, clarified that resource deeming is for F&C MN covered groups only. Page 30 is a reprint. On page 32, updated reference to MI child covered group. On page 35, clarified that resource deeming is for F&C MN covered groups only. Page 36 is a runover page. On page 37, revised examples. On page 38, deleted income eligibility determination.</p>
Subchapter M0610 pages 1-4	Subchapter M0610 pages 1-4	<p>On pages 1-3, revised the policy on resource requirements for the F&C covered groups. Page 4 is a reprint.</p>
Subchapter M0630 Table of Contents pages 1-6	Subchapter M0630 Table of Contents pages 1-6	<p>Updated the Table of Contents. Page 1 is a reprint. On page 2, corrected the reference to savings/investment self-sufficiency accounts. On pages 3-6, revised the policy on resource requirements for the F&C covered groups.</p>
Subchapter M0640 Table of Contents pages 1-6	Subchapter M0640 Table of Contents pages 1-6	<p>Updated the Table of Contents. On page 1, revised the section format and references. Pages 2 and 3 are reprints. On page 4, revised reference to covered groups under motor vehicle policy. On page 5, added policy for disputing vehicle value and clarified the MN policy on automobile exclusion when more than one vehicle is owned. On page 6, revised the section title.</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0710 pages 1, 2 pages 11, 12	Subchapter M0710 pages 1, 2 pages 11, 12	On page 1, clarified the policy for income verification. Page 2 is a runover page. Page 11 is a reprint. On page 12, clarified that the income eligibility determination for the VIEW participant is a family unit calculation.
Subchapter M0720 pages 1, 2	Subchapter M0720 pages 1, 2	Page 1 is a reprint. On page 2, clarified the policy for income verification.
Subchapter S0830 pages 15, 16	Subchapter S0830 pages 15, 16	Page 15 is a reprint. On page 16, added the QDRO as an exception to the unearned income policy.
Subchapter M1130 pages 17, 18	Subchapter M1130 pages 17, 18	On page 17, clarified the policy on automobile exclusion when more than one automobile is owned. On page 18, corrected the definition of cash surrender value.
Subchapter M1410 pages 3-6	Subchapter M1410 pages 3-6	On page 3, revised the reference for assignment of rights and support cooperation. Pages 4 and 5 are reprints. On page 6, revised the definition of the CDPAS waiver to eliminate the competency and age requirements.
Subchapter M1430 pages 3, 4	Subchapter M1430 pages 3, 4	On page 3, revised references for the non-financial requirements. Page 4 is a reprint.
Subchapter M1440 pages 17, 18	Subchapter M1440 pages 17, 18	On page 17, revised the eligibility rules for the CDPAS waiver to eliminate the

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1470 pages 9-12	Subchapter M1470 pages 9-12	competency and age requirements. On page 18, clarified the supervision and provider requirements. Page 9 is a reprint. On pages 10-12, revised the process for DMAS to authorize the allowable amount of medical expense deductions that exceed \$500. On page 11, clarified the documentation required for adjustments to patient pay.
Subchapter M1480 pages 51, 52 pages 65, 66	Subchapter M1480 pages 51, 52 pages 65, 66	On page 51, added policy for an expected contribution from the community spouse. Page 52 is a runover page. Page 65 is a reprint. On page 66, updated the utility standard deduction effective October 1, 2003.
Subchapter M1510 pages 1, 2 pages 7, 8	Subchapter M1510 pages 1, 2 pages 7, 8	Page 1 is a reprint. On page 2, removed the resource test from Example #1. On page 7, revised the policy on entitlement of MI pregnant women to include eligibility in the FPS covered group. On page 8, clarified the policy on subsequent disability decisions.
Subchapter M1520 pages 5-8	Subchapter M1520 pages 5-8	On page 5, revised the policy on redeterminations for MI pregnant women and enrollment in the FPS covered group. On page 6, revised the reference to the MI Child Under Age 19 (FAMIS Plus) covered group and the policy on entitlement for women in the FPS covered group. Page 7 is a runover page. Page 8 is a reprint.

Remove and Destroy Pages

Insert Attached Pages

Significant Changes

Subchapter M21
Appendix 2

Subchapter M21
Appendix 2

Updated the list of Local Choice
agencies in Appendix 2

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



Duke Storen, Director
Division of Benefit Programs

Attachments

Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you can apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid/FAMIS Plus/FAMIS
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Auxiliary Grants
- Refugee Resettlement Program

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is correct, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The **INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS)** will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the Immigration and Naturalization Service (INS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

032-03-824/16 (6/03)

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can apply for Food Stamps by leaving a completed Application for Benefits at the agency or by leaving a partially completed Application with at least your name, address, and signature, or by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined.**

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your application.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and if your gross monthly income is less than \$150 and liquid resources are \$100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farm worker household with little or no income and resources. **GIVE THE INFORMATION BELOW SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	\$ _____
Total cash, money in checking/savings accounts, CDs	\$ _____
Total rent or mortgage for this month	\$ _____
Total utility expenses for this month	\$ _____
Do not count amounts due for previous months. Count only the basic telephone service cost.	
Is anyone in your household a migrant or seasonal farm worker	YES () NO ()

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

AGENCY USE ONLY		
CASE NAME		
CASE NUMBER		
LOCALITY	WORKER	DATE

EXPEDITED SERVICE DETERMINATION

Income less than \$150 and Resources \$100 or less YES () NO ()

Income plus resources less than shelter bills YES () NO ()

For migrants or seasonal farm workers:

Resources \$100 or less, and in next 10 days \$25 or less is expected from new income:

OR

Resources \$100 or less, and no income is expected from a terminated source for the rest of this month or next month. YES () NO ()

EXPEDITE IF YES TO ANY OF THE ABOVE.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required. However, if you decided not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

**VIRGINIA SOCIAL SERVICES
BENEFIT PROGRAMS BOOKLET**

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages. If you want Medicaid and you are under 18 years of age, your parent or legal guardian must sign the application.

FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), but you must complete the rest of this Application before your eligibility can be determined. For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

YOUR FOOD STAMP RIGHTS

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs and disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

**VIRGINIA DEPARTMENT
OF SOCIAL SERVICES
APPLICATION FOR BENEFITS**

CASE NAME	CASE NUMBER	AGENCY USE ONLY		DATE REC'D.
		PROGRAM	WORKER CASELOAD	
DATE OF SERVICE REFERRAL	DATE OF INTERVIEW	LOCALITY		

1. I am requesting: () Food Stamps () TANF () Medicaid/FAMIS Plus/FAMIS () Other Financial or Medical Assistance
() I understand that an application for TANF is also an application for Food Stamps and I do not wish to apply for Food Stamps.

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	PHONE NUMBER (HOME/MESSAGES)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)		
LANGUAGE (Enter Code) _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C - Arabic F - French G - German J - Japanese O - Other		
YES () NO () A. Does anyone have an emergency medical need? If YES, give name and explain _____		
YES () NO () B. Is the applicant living in an Assisted Living Facility, an Adult Family Care Home, a Nursing Facility, or other institution? If YES, Date Applicant Entered _____ City/County and State Applicant lived before entering _____ If outside Virginia, was placement made by a government agency? YES () NO ()		
YES () NO () C. ANSWER THIS QUESTION IF APPLYING FOR MEDICAID, GENERAL RELIEF OR AUXILIARY GRANTS: Does this applicant have a spouse who does not live in the home? If YES, Spouse's Name _____ Spouse's Address _____		

2. YES () NO () Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance?
 SOCIAL SECURITY NUMBER _____ TYPE OF BENEFITS RECEIVED _____

3. YES () NO () Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, Food Stamps, or Medicaid in two or more states at the same time? If YES, give date and place of conviction _____

4. YES () NO () Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If YES, explain _____

5. YES () NO () Have you or anyone for whom you are applying been convicted of a felony for actions that occurred after August 22, 1996, for possession, use or distribution of drugs? If YES, explain _____

6. YES () NO () Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, referrals to other community organizations, or other problems or concerns. If YES, explain _____

032-03-824/16 (6/03)

INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.
2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION**. Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.
3. Answer the questions in **SECTION B: RESOURCES**, unless you are applying for FAMIS Plus/FAMIS, for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid** also provide resource information for the following persons:
 - TANF:** Children age 18 or under, even if you are not applying for that child.
 - Medicaid:** Spouse and children under age 21 who live with a person for whom you are applying.
Parents who live with a child under age 21.
Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.
4. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid or FAMIS Plus or FAMIS** also provide income information for the following persons:
 - TANF:** Children age 18 or under, even if you are not applying for that child.
 - Medicaid:** Spouse and children under age 21 who live with a person for whom you are applying.
Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.
 - FAMIS Plus/FAMIS** Parents and stepparents who live with a child under age 21.
5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.
 - Food Stamps** Section D pp. 8-9
 - TANF/Medicaid** Section E p. 10
 - Refugee Resettlement Program** Section E p. 10 **only** for children age 18 and under
 - FAMIS Plus/FAMIS** Section F p. 11
 - Medicaid/Auxiliary Grants/General Relief** Section G p. 11
 - General Relief** Section E p. 10 **only** for children under age 18
Sections I & J p. 12
 - State and Local Hospitalization** Section H p. 12
 - Emergency Assistance** Section J. p. 12
 - Auxiliary Grants** Section K p. 12
6. Read **YOUR RESPONSIBILITIES** on page 13.
7. Read and complete **VOTER REGISTRATION** on page 13 of this application.
8. Read and complete the last page of this application. Be sure to sign and date the application.

A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. EVERYONE IN YOUR HOME LIST EVERYONE LIVING IN YOUR HOME, even if you are not applying for assistance for that person. LIST YOURSELF ON LINE #1. Check (✓) YES () NO () Do you expect any change in who lives in your home, either this month or next month? If YES, explain: LAST NAME, FIRST, MI, AND MAIDEN (DO NOT make any entry in the ID# space)	2. TEMPORARILY AWAY FROM HOME Is this person temporarily away from home? Check (✓) YES or NO If YES, give the date the person left and expected return date. If more than 45 days, give the reason for the absence.	3. RELATIONSHIP TO PERSON ON LINE #1 Give the relationship of each person to the person listed on Line #1.	4. TYPE OF ASSISTANCE REQUESTED Check (✓) type of assistance requested for each person. If no assistance is requested, check NONE for that person.								
			FOOD STAMPS	TANF	MEDICAID/FAMIS Plus/FAMIS	GENERAL RELIEF	EMERGENCY ASSISTANCE	STATE & LOCAL HOSPITALIZATION	AUXILIARY GRANTS	REFUGEE RESETTLEMENT PROGRAM	NONE
1 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										
2 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										
3 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										
4 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										
5 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										
6 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										
7 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										
8 ID# _____ YES () NO () Date Left _____ Expected Return Date _____ Reason _____	YES () NO () Date Left _____ Expected Return Date _____ Reason _____										

Determine reason person is away.
Determine if any parents or spouses live in the home.
Determine if person under 18 are under parental control.
Determine if anyone is a payee for anyone else.

Determine living arrangement, such as subsidized housing for elderly, hospital, incarceration, etc.
If person is in ALF, nursing facility, state hospital, or CBC, determine if a spouse, dependent, child, or dependent relative is in the home.
Determine living arrangement of the minor parent.

USE THE FOLDDOUT TO COMPLETE THIS SECTION

5. U.S. CITIZEN	6. ANSWER ONLY IF AN ALIEN	7. PLACE OF BIRTH	9a. RACE (not required)	9b. ETHNICITY (not required)	10. SEX	11. SOCIAL SECURITY NUMBER	12. MARITAL STATUS	13. VETERAN OR DEPENDENT OF A VETERAN
Check (X) YES or NO If YES, do not answer Question 6. You may leave this blank for anyone not in the assistance request.	Give the Alien Number and Date of Entry for anyone for whom you are requesting assistance. You may leave this blank for anyone not in the assistance request.	Give the State if born in the U.S. or the Country if born outside of the U.S. 8. DATE OF BIRTH	Give the code from the list at the bottom of the page to show Race.	Give the code to show Ethnicity. 1 - Hispanic or Latino 2 - Not Hispanic or Latino	Give the code to show Sex. M - Male F - Female	Give the number for anyone for whom you are requesting assistance.	Give the code to show Marital status. 1 - Married 2 - Never Married 3 - Divorced 4 - Widowed 5 - Separated	Check (X) YES or NO
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()

Race Code List: 1 - White 2 - Black/African American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander 6 - American Indian/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other

For Aliens, photocopy INS document. Inquire if requesting emergency care. Determine if sponsored. Obtain sponsor's name address, income, and resources. For Asylees, verify date asylum was granted. For Veterans, make referral to VA. For Medical Expenses, determine retroactive Medicaid entitlement.

USE THE FOLDOUT TO COMPLETE THIS SECTION

14. MEDICAL EXPENSES DURING THE 3 MONTHS BEFORE THIS MONTH. Check (✓) YES or NO If YES, give the Date of the Expense.	15. EDUCATION Give the Last Grade Completed in school. Check (✓) YES or NO Is the person a High School (HS) or GED graduate? Check (✓) YES or NO Is the person Currently Enrolled in school? If YES, give the school name and use one of the codes to show enrollment. FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time	16. DISABILITY/PREGNANT STATUS Give the code to show Disability/Pregnant Status ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabled person PG - Pregnant	17. ANSWER ONLY IF DISABLED A. Check (✓) if the disability reduces or prevents the ability to work or to obtain work. B. Check (✓) if the disability reduces or prevents the ability to care for a child in the home. C. Check (✓) if the disability requires someone to be in the home to provide care.	18. ANSWER ONLY IF PREGNANT AND APPLYING FOR MEDICAID Give the Conception month and year and the Expected Delivery Date, and the number of Unborn Children.
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn

B. RESOURCES

Answer the resource questions for everyone for whom you are applying unless you are applying for FAMIIS Plus or FAMIIS. If applying for TANF or Medicaid, also provide resource information for the additional persons indicated on the INSTRUCTIONS page. Include any resources anyone owns, is currently buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

YES () NO () 1. Cash on hand and not in a bank? If YES, list owner(s) _____ Amount _____
 YES () NO () 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If Yes to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (✓) YES () NO () If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid _____ If the savings or investment account is for another purpose, explain _____

OWNER(S)	ACCOUNT #	WHERE	YES () NO () Is this resource used in your business or trade, including farming?	AMOUNT	DATE ACQUIRED
	TYPE OF ACCOUNT	WHERE	YES () NO () Is this resource used in your business or trade, including farming?	AMOUNT	DATE ACQUIRED
	ACCOUNT #	WHERE	YES () NO () Is this resource used in your business or trade, including farming?	AMOUNT	DATE ACQUIRED

YES () NO () 3. Stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, or deeds of trust?

OWNER(S)	ACCOUNT #	WHERE	AMOUNT	DATE ACQUIRED
	TYPE OF ACCOUNT	WHERE	AMOUNT	DATE ACQUIRED
	ACCOUNT #	WHERE	AMOUNT	DATE ACQUIRED

YES () NO () 4. Burial plots, burial arrangement or trust funds for burial?

OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE	DATE ACQUIRED
	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE <td>DATE ACQUIRED</td>	DATE ACQUIRED
	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE <td>DATE ACQUIRED</td>	DATE ACQUIRED

YES () NO () 5. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES () NO () Is this property necessary to your business or trade, including farming?	VALUE	DATE ACQUIRED
	TYPE	YES () NO () Is this property necessary to your business or trade, including farming?	VALUE <td>DATE ACQUIRED</td>	DATE ACQUIRED
	TYPE	YES () NO () Is this property necessary to your business or trade, including farming?	VALUE <td>DATE ACQUIRED</td>	DATE ACQUIRED

YES () NO () 6. Real property, including life estates, land, buildings, or mobile homes? If YES, do you live there? Check (✓) YES () NO ()

OWNER(S)	TYPE (INCLUDE NUMBER OF ACRES)	YES () NO () Currently rented	YES () NO () Income producing	YES () NO () Currently for sale	VALUE	DATE ACQUIRED
	TYPE (INCLUDE NUMBER OF ACRES)	YES () NO () Currently rented	YES () NO () Income producing	YES () NO () Currently for sale	VALUE	DATE ACQUIRED
	TYPE (INCLUDE NUMBER OF ACRES)	YES () NO () Currently rented	YES () NO () Income producing	YES () NO () Currently for sale	VALUE	DATE ACQUIRED

YES () NO () 7. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?

OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES () NO ()	LICENSE #	VALUE \$ AMOUNT OWED	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES () NO ()	LICENSE #	VALUE \$ AMOUNT OWED	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED

YES () NO () 8. Health insurance?

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE	END DATE	ID NUMBER	PREMIUM AMOUNT	TYPE OF COVERAGE	PERSON(S) INSURED
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE	END DATE	ID NUMBER	PREMIUM AMOUNT	TYPE OF COVERAGE	PERSON(S) INSURED

YES () NO () 9. Medicare?

PERSON INSURED	CLAIM NUMBER	CHECK (N) () PART A () PART B	BEGIN DATE	END DATE	PREMIUM	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (N) () PART A () PART B	BEGIN DATE	END DATE	PREMIUM	PAYMENT METHOD

YES () NO () 10. Life insurance policies? (NOT REQUIRED IF YOU ARE APPLYING ONLY FOR FOOD STAMPS)

OWNERS	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE	CASH VALUE	DATE ACQUIRED
OWNERS	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE	CASH VALUE	DATE ACQUIRED

YES () NO () 11. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for Food Stamps? In the last 2 years, if applying for TANF or General Relief? Any resources or income in the last 5 years if applying for Medicaid?

PROPERTY TRANSFERRED	VALUE AT TRANSFER	AMOUNT RECEIVED	EXPLAIN REASON FOR TRANSFER
FROM WHOM	TO WHOM	DATE ACQUIRED	DATE TRANSFERRED

YES () NO () 12A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If YES, explain.
YES () NO () 12B. Does anyone expect a change in resources this month or next month? If YES, explain and give date change is expected.

EXPLAIN

C. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. If applying for TANF or Medicaid, also provide income information for the additional persons indicated on the INSTRUCTIONS page. And for TANF and for Medicaid/FAMIS Plus/FAMIS for children, also provide income information for the child's parent or stepparent living in the home, or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for TANF) or under age 21 (for Medicaid), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (Y) YES or NO for each type. If YES, give the information requested.

PERSON RECEIVING MONEY FROM WORKING	EMPLOYER'S NAME ADDRESS, PHONE NUMBER	EMPLOYMENT BEGIN DATE	HOURS WORKED PER MONTH	RATE OF PAY PER HOUR	HOW OFTEN PAID	DAY OF THE WEEK PAID	GROSS MONTHLY PAY BEFORE DEDUCTIONS FROM WORKING
				\$ PER			\$
				\$ PER			\$
				\$ PER			\$

2. Does anyone receive any other type of money? Check (Y) YES OR NO for each type. If YES, give the information requested.

PERSON RECEIVING MONEY	TYPE OF MONEY RECEIVED	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMOUNT BEFORE DEDUCTIONS
				\$
				\$
				\$

For Self Employment Income, determine expenses.
 For Day Care Income, determine whether child lives in the home, number of snacks or meals, expenses.
 For Roomer/Boarder Income, determine whether heat is provided, number of meals provided per day.
 For Rental Income, determine whether property is actively self-managed, expenses.
 For Earned Income, determine whether earnings include EITC advance payments.
 Inquire if SSI has been applied for.
 For Food Stamps, investigate voluntary quit/work reduction.
 For TANF, determine the day care option.
 For Medicaid, determine income of spouse, dependent child or dependent relative of person in nursing facility, state hospital, or CRC.

YES () NO () 3. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

NAME OF PERSON	EMPLOYER'S NAME, ADDRESS PHONE	EMPLOYED FROM/TO	HRS./WK. WORKED	RATE OF PAY	HOW OFTEN PAID	DATE LAST PAY RECEIVED	REASON FOR LEAVING, REDUCING HOURS
				\$ PER			

YES () NO () 4. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? Or, does anyone totally provide food or clothing for you or someone else on a regular basis?

PERSON RECEIVING HELP	PERSON PROVIDING HELP	TYPE OF HELP RECEIVED	AMOUNT	DOES MONEY COME DIRECTLY TO YOU?	IS THIS A LOAN?	IS REPAIRMENT EXPECTED
			\$ PER	YES () NO ()	YES () NO ()	YES () NO ()
			\$ PER	YES () NO ()	YES () NO ()	YES () NO ()

YES () NO () 5. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED		SCHOOL EXPENSES					
			FROM	TO	TUITION FEES	BOOKS/ SUPPLIES	TRANSPOR- TATION	DEPENDENT CARE	ROOM & BOARD	OTHER (Specify)
		\$			\$	\$	\$	\$	\$	\$
		\$			\$	\$	\$	\$	\$	\$

YES () NO () 6. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If YES, explain and give date: _____

YES () NO () 7. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

PERSON PAYING FOR CARE	PERSON RECEIVING CARE	CHECK (X) IF DISABLED	PROVIDER'S NAME, ADDRESS, PHONE NUMBER	AMOUNT PAID
		() Disabled		\$ PER
		() Disabled		\$ PER

YES () NO () 8. Does anyone pay legally obligated child support to someone not in the household? If YES, person paying: _____

Person supported: _____ Amount paid and how often: _____

YES () NO () 9. ANSWER ONLY IF SOMEONE IS APPLYING FOR MEDICAID AND IS BLIND OR DISABLED: Does this person have a work related expense?

If YES, give amount and explain: _____

D. FOOD STAMPS

1. List the name of the person who is the head of your household: _____

NOTE: Refer to the Benefit Programs Booklet for information about naming the Head of Household.

YES () NO () 2. Would you like to name an authorized representative who could apply for food stamps for you, access your food stamp account to buy food for you, or receive food stamp correspondence and notices for you? You may have only one representative who can access your benefits.

NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)	CHECK (✓) EACH DUTY AUTHORIZED FOR THAT PERSON
1	<input type="checkbox"/> Apply for food stamps <input type="checkbox"/> Receive food stamps <input type="checkbox"/> Apply for food stamps <input type="checkbox"/> Receive correspondence
2	<input type="checkbox"/> Apply for food stamps <input type="checkbox"/> Receive food stamps

An authorized representative must have written permission to apply for food stamps. This permission may be given in the space above or in a letter. Only the head of the household, the spouse, or any adult member of the household age 18 or older may give permission for a representative.

YES () NO () 3. Is anyone living in your home NOT included on your Food Stamp application?

If YES, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for Food Stamps is approved? Check (✓) YES () NO () IF YES, list names: _____

YES () NO () 4. Is anyone living in your home a roomer or a boarder? If YES, list names: _____

YES () NO () 5. Is anyone age 60 or older OR approved to receive Medicaid because of a disability, OR receiving any type of disability check?

If YES, list all current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		\$		<input type="checkbox"/> Lump sum <input type="checkbox"/> Monthly average <input type="checkbox"/> Expected payment
		\$		<input type="checkbox"/> Lump sum <input type="checkbox"/> Monthly average <input type="checkbox"/> Expected payment
		\$		<input type="checkbox"/> Lump sum <input type="checkbox"/> Monthly average <input type="checkbox"/> Expected payment

YES () NO () 6. Does anyone have any shelter expenses for rent or mortgage, real estate tax, property tax on a mobile home, home owner's insurance, electricity, gas, kerosene, coal, oil, wood, water or sewer, telephone, or initial installation fee for utilities or telephone? If YES, answer questions a, b, and c. Then, give the information requested in boxes.

- a. YES () NO () Are any utilities included in your rent? If Yes, leave the boxes for those expenses blank.
- b. YES () NO () Are taxes or insurance included in your mortgage payment? If Yes, leave those boxes blank.
- c. YES () NO () Do you have an expense for telephone services? If Yes, does anyone living in your home but not included on your Food Stamp application help you pay your telephone bill? Check (✓) YES () or NO ()

If YES, explain: _____

EXPENSE	Rent or Mortgage	Taxes	Insurance	Electricity	Gas	Kerosene	Coal	Oil	Wood	Water/Sewer	Garbage	Installation
AMOUNT BILLED	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
HOW OFTEN												
WHO PAYS BILL												

YES () NO () 7. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If YES, check (✓) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. Actual Utility Expenses () Utility Standard ()

If the Utility Standard is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (✓) YES () NO () If YES, explain: _____

YES () NO () 8. Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If temporarily staying in someone else's home, give the date you moved in: _____

If YES, check (✓) whether you would like your food stamp benefits determined using your actual shelter expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. Actual Shelter Expenses () Homeless Shelter Allowance ()

YES () NO () 9. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from home, illness, or a disaster?

REASON FOR NOT LIVING THERE	DOES PERSON INTEND TO RETURN?	TYPE AND AMOUNT OF SHELTER EXPENSES	IS SOMEONE ELSE LIVING THERE?	IF SOMEONE ELSE LIVES THERE, DOES THAT PERSON PAY RENT?
	YES () NO ()		YES () NO ()	YES () NO ()

E. FINANCIAL AND MEDICAL ASSISTANCE FOR FAMILIES WITH CHILDREN

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. YOU MUST IDENTIFY BOTH PARENTS IN ORDER TO RECEIVE TANF. IF YOU INTENTIONALLY MISIDENTIFY A PARENT, YOU SHALL BE PROSECUTED	2. PARENT'S STATUS Check if either PARENT is:				3. REASONS FOR ABSENCE (Answer only if the answer to question 2 is "absent" and you are applying for Medicaid.) For each ABSENT PARENT, check reason for absence.								4. FINANCIAL SUPPORT Does the ABSENT PARENT regularly provide monthly financial support? Check (X) YES or NO If YES, give amount, and how often received.		5. PHYSICAL CARE Does the ABSENT Parent regularly make sure the child eats, sleeps, bathes, dresses properly, and gets proper medical care? Check (X) YES or NO		6. GUIDANCE Does the ABSENT PARENT regularly participate in the child's activities, attend school conferences, and share in decisions about discipline? Check (X) YES or NO		7. IMMUNIZATION (Answer only if applying for TANF and the child is not in school.) Has the child received ALL of the immunizations required according to the child's age? Check (X) YES or NO or UNKNOWN	
	UNEMPLOYED	DISABLED	DEAD	ABSENT	PATERNITY NOT ESTABLISHED	DIVORCED OR MARRIAGE ANNULLED	INCAPACITATED	DESERTED	SEPARATED LIVING APART	SENTENCED BY COURT TO DO UNPAID WORK	DEPORTED	ARTIFICIAL INSEMINATION	SINGLE PARENT ADOPTION	\$	PER	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO () UNKNOWN ()
CHILD'S NAME																				
MOTHER																				
FATHER																				
CHILD'S NAME																				
MOTHER																				
FATHER																				
CHILD'S NAME																				
MOTHER																				
FATHER																				
CHILD'S NAME																				
MOTHER																				
FATHER																				

F. FAMIS PLUS/FAMIS

YES () NO () 1. Did any of the children listed above have health insurance in the past 4 months? If yes, (a) list name of child, type of insurance, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) select the reason the insurance ended.

Child: _____ Type of insurance: _____

Date ended _____

Reason insurance ended:

- The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.
- The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.
- Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)
- Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)
- Stopped/dropped by someone other than parent or stepparent.
- Stopped/dropped Cobra policy
- Other _____

YES () NO () 2. Is any member of the family, including a stepparent who lives in the home, employed by a State or Local Government agency? If yes, list name of family member(s) and agency name: _____

YES () NO () 3. Does the employer of any member of the family offer health insurance for family members? If yes, list the names of the children listed on this application who can get insurance through the employer? _____

G. AGED, BLIND, OR DISABLED INDIVIDUALS

YES () NO () 1. Have you ever applied for Supplemental Security Income (SSI) or social security as a disabled person? If YES, date applied: _____
Check one: () No Decision Yet () Application Approved () Application Denied

YES () NO () 2. If your application was denied, did you file an appeal of the denial? If yes, explain the action taken by the Social Security Administration (SSA) on the appeal request? _____

YES () NO () 3. Has it been less than 12 months since your most recent application for Social Security or SSI disability benefits was denied? If yes, list the medical conditions that you asked SSA to evaluate. _____

YES () NO () 4. Has your condition changed or worsened since your most recent application for Social Security or SSI disability benefits was denied. If yes, explain how your condition has changed or worsened. _____

YES () NO () 5. Do you have a new condition that has occurred since your most recent application for Social Security or SSI disability benefits was denied? If yes, explain the new condition. _____

YES () NO () 6. Did you receive an Auxiliary Grants check that has stopped? If yes, explain when and why the payments stopped. _____

YES () NO () 7. Did you receive a SSI check that has stopped? If yes, explain when and why the payments stopped. _____

H. STATE AND LOCAL HOSPITALIZATION

YES () NO () Have you received or will you be receiving in-patient/out-patient hospitalization services, or ambulatory surgical services, or services through a health department clinic? If YES, please fill out the following:

PERSON RECEIVING SERVICES	NAME OF HOSPITAL OR CLINIC	IF SERVICE HAS ALREADY BEEN RECEIVED, GIVE THE DATES BELOW DATE ADMITTED: _____ DATE DISCHARGED: _____
---------------------------	----------------------------	---

If you were hospitalized as the result of an accident, complete the following:

WHAT HAPPENED, WHERE, HOW	NAME, ADDRESS OR PERSON AT FAULT	IS A LIABILITY SUIT PLANNED OR IN PROGRESS? YES () NO ()
NAME, ADDRESS OF ALL INSURANCE COMPANIES INVOLVED		NAME, ADDRESS, PHONE NUMBER OF YOUR ATTORNEY

I. GENERAL RELIEF

YES () NO () Does anyone have any responsibility for rent or utility bills (not telephone), even if someone else helps pays?

J. GENERAL RELIEF/EMERGENCY ASSISTANCE

YES () NO () Does anyone have any emergency food, rent, utility (not deposits), medical, clothing, transient or relocation expenses?

DESCRIPTION AND CAUSE OF EMERGENCY

K. AUXILIARY GRANTS

YES () NO () 1. Do you own any household goods or personal effects which are worth more than \$500, such as silver, fine china, furs, artworks, expensive jewelry, or other expensive items?

DESCRIPTION AND VALUE OF ITEMS

YES () NO () 2. Do you owe or did you pay in the month of application any bills you had before you entered the assisted living facility or adult family care?

DESCRIPTION OF BILLS	DATES OF BILLS	DATES BILLS PAID
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YOUR RESPONSIBILITIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

CHANGES

You must report the following changes for the Medicaid/FAMIS Plus Programs within 10 days. You must report these changes for the Auxiliary Grants and General Relief Programs the day the change occurs or the first day that the agency is open after the change occurs. The following examples of changes may include some that do not have to be reported for every program. If you are not sure whether to report a particular change, please discuss the change with your worker.

- 1) Change of address and any changes in shelter costs due to the move
 - 2) Change in the persons in the household – person left, person born, etc.
 - 3) Change in source of income, getting a new job, stopping a job, other benefits, etc.
 - 4) Change in work hours from part-time to full-time or full-time to part-time
 - 5) Change in rate of pay per hour/day, etc.
 - 6) Change in the amount of monthly income received other than from a job.
 - 7) Change in resources
 - 8) Change in motor vehicles owned
 - 9) Change in marital status
 - 10) Person in home is no longer disabled
 - 11) Change in dependent care expenses
 - 12) Other changes that may affect eligibility for a program or the amount of assistance
- You must report the following changes for the Food Stamp and Temporary Assistance for Needy Families (TANF) Programs within 10 days.
- 1) Change in household income that exceeds 130% of the Federal poverty level. See the Change Report for amounts.
 - 2) Change in address.

- 3) Changes needed for VIEW (TANF work program).
- 4) Change in work hours for some food stamp recipients.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell EBT cards. You must not use food stamp benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's EBT card for your household.

Anyone who intentionally breaks any of these rules could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); subject to \$250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

Anyone who intentionally gives false information or hides information about identity or residence to get food stamps in more than one locality at the same time could be barred for 10 years.

Anyone court convicted of trading or selling food stamps of \$500.00 or more could be barred permanently.

Anyone court convicted of trading food stamps for a controlled substance could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

Anyone court convicted of trading food stamps for firearms, ammunition, or explosives could be barred permanently for the first violation.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law. Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, Food Stamps or SSI in two or more states is ineligible for TANF for 10 years.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

INFORMATION ABOUT THE DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to DCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights.

VOTER REGISTRATION

Check one of the following:

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

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

Agency Use Only: Face-to-face interview not required. A voter registration form was mailed.

BY MY SIGNATURE BELOW, I DECLARE:

- I understand all other information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Control, my benefits may be denied until I cooperate.
- I understand that if my application is for Food Stamps, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.
- I understand that Medicaid, FAIMS, and DMAS contractors may exchange information relating to my child(ren)'s coverage with local educational agencies, to assist with application, enrollment, administration, and billing for services provided to my child in schools. I understand that I can revoke the consent to disclose information at any time.
- I understand that to receive benefits from the Medicaid/FAIMS Plus/FAIMS programs, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that I have the right to file a complaint if I feel I have been discriminated against because of race, color, national origin, sex, age, handicap, or religious belief.
- I understand that if I am applying for Medicaid/FAIMS Plus/FAIMS for my children, I can apply for and receive services from the Division of Child Support Enforcement, but failure to apply for the services will not affect my child(ren)'s eligibility. If I am applying for Medicaid, failure to cooperate my cause my ineligibility for Medicaid.
- I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within specified time frames 10 days; (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of Medicaid/FAIMS Plus. For FAIMS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.
- I will report any changes in my situation within the time frames specified on page 13 to my local department of social services.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted
- I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. Citizen or alien in lawful immigration status.
- I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verification necessary to both determine and review financial or medical assistance eligibility. This authorization includes the release of any medical or psychological information obtained from any source to any state or local agency that may review this application and the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or anyone for whom I applied. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I received the Benefit Programs Booklet YES () NO ()

TANF APPLICANTS:

The diversionary assistance program was explained to me. YES () NO ()
 The family cap provision was explained to me. YES () NO ()

I filled in this application myself. YES () NO () If NO, it was read back to me when completed. YES () NO ()

APPLICANT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

Complete the box below if this application was completed for the applicant by someone else.

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME)	(WORK)	RELATIONSHIP TO APPLICANT



Children's Health Insurance

This is an application for FAMIS and FAMIS Plus, Virginia's health insurance programs for children under age 19. Instructions are attached.

Application is: _____ a new application
to continue insurance

Family ID # _____

Office Use Only: Case _____
Worker _____

Step 1

Information on the person completing the application:
Tell us who you are, where you live and where you get your mail.

First Name	MI	Last Name	Phone Numbers	Preferred Language? (See instructions)
Address		Appt No.	City	State
(Street)				ZIP
(Mailing)				City/County of Residence

Step 2

Information on Children:
Tell us about **all** the children under age 21 living in your home. If there are more than four children in the home, please complete steps 2 and 3 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (Name: First, MI, Last)				
Relationship to You				
Date of Birth & Sex	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F			
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required

Step 3

Information on Children Applying for Insurance:

	Child 1 <i>continued</i>	Child 2 <i>continued</i>	Child 3 <i>continued</i>	Child 4 <i>continued</i>
Child's Full Name (Name: First, MI, Last)	_____	_____	_____	_____
Applying for Health Insurance for Child?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you are applying for insurance for this child, answer the questions below. If you are <u>not</u> applying for this child, you may leave them blank.				
Is Child a US Citizen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child Social Security # or Date of Application for SS#	If No, Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____		If No, Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	
	(SS#) _____	(SS#) _____	(SS#) _____	(SS#) _____
Child Attends School?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child's Race (See codes listed below)	Race Code # _____			
Child's Ethnicity	RACE CODES: 1 White, 2 Black/African American, 3 American Indian/Alaskan Native, 4 Asian, 5 Spanish American/Hispanic, 6 Native Hawaiian or Other Pacific Islander, 9 Other or Unknown.			
	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	If YES, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____		If YES, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	If YES, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____		If YES, Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason # _____ Other _____		Reason # _____ Other _____	
	<p>REASONS CHILD'S HEALTH INSURANCE ENDED: (See instructions)</p> <p>1 Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. 2 Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. 3 Insurance company discontinued coverage because child is uninsurable. 4 Cost of insurance exceeded 10% of monthly income (before taxes). 5 Insurance stopped/dropped by someone other than parent or stepparent living with child. 6 Stopped/dropped a COBRA policy. 7 Other</p>			

Step 4

Income Information:

Complete the section below for each parent, stepparent and child living in the home receiving income. List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write "NONE" in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)

Person Receiving Income	Employer's Name or Source of Income?	Is Employer a State or Local Government?	How Much Income is Received?	How Often is Income Received?
First Name _____ MI _____ Last Name _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name _____ MI _____ Last Name _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name _____ MI _____ Last Name _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name _____ MI _____ Last Name _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name _____ MI _____ Last Name _____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

We have your permission to get information from the above employers, if necessary, about dates of employment and earnings. YES NO

Step 5

Childcare Expenses:

Do you pay someone to provide childcare while you work? YES NO If yes, provide information for each child in childcare.

(Child's name: First, MI, Last)	How much do you pay? \$ _____	How often?	(Child's name: First, MI, Last)	How much do you pay? \$ _____	How often?	(Child's name: First, MI, Last)	How much do you pay? \$ _____	How often?
_____	_____	_____	_____	_____	_____	_____	_____	_____

You're almost done. Turn the page over. Complete the application and remember to sign it.

Step 6

Help with Medical Bills:

If the child is eligible, FAMIS Plus may be able to help you with medical/dental services the child received in the last 3 months. Did any child you are applying for receive medical/dental services in the last 3 months? YES NO

If yes, list names of children and months in which they received medical/dental services:

Provide proof of income for the months that child received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS TO FAMIS.**

Step 7

Release:

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____

and/or (organization) _____

(address) _____

(city) _____ (state) _____ (zip) _____ (phone) _____

to request and receive eligibility/enrollment information relating to my child(ren). I also permit FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, my children's health insurance may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

SIGNATURE (REQUIRED) _____

DATE _____



Children's Health Insurance

Application Instructions & Rights and Responsibilities

APPLICATION INSTRUCTIONS FOR FAMIS & FAMIS Plus

(FAMIS Plus is the new name for children's Medicaid)

How do I apply?

To get started, simply call our toll-free number **1-866-87-FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS P.O. Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off or faxed to the **local Department of Social Services** in the City or County in which you live. Check the blue pages in your telephone book for the address and telephone number of your local Department of Social Services. It is not required that you visit FAMIS or your local Department of Social Services to apply.

Who can apply for a child?

Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse, and children over 18 or emancipated by a court, may apply for themselves.

Step 1 Information on person completing application: Complete this section listing your name, address and phone number. If we may call you at work, include that phone number. Please tell us what language you prefer. Write the name of the language you prefer in the space provided, such as:

English, Spanish, Cambodian, Vietnamese, Farsi, Haitian-Creole, Laotian, Chinese, Korean, Somali, Kurdish, Arabic, French, German, Japanese, or any other language.

Step 2 Information on children: Provide information on all children under 21 who live in the home with you even if they are not applying for FAMIS or FAMIS Plus. Although you can only apply for children under age 19 on this form, we need information on all children under 21 to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete sections 2 and 3 on another application and attach it to this one.

List the **name** of each child under age 21 who lives in the home with you, tell us how they are **related to you**, their **date of birth**, and check if they are **male or female**.

For each child under age 21 in the home please write the **name** of the child's **parents and/or stepparents** living in the home with the child. Check if they are the Mother, Father or Stepparent of the child. The Social Security Number (SS#) of each parent is not required information but it helps us check income and process the application. If you prefer, you may leave it blank.

Step 3 Information on children applying: Write the **name** of each child at the top of the same column again. Check whether you are **applying for health insurance** for each child. If you are not applying for health insurance for a child, you do not need to answer the rest of the questions in this section for that child. If you are applying for the child, answer all of the questions in the column.

If the child is a **US citizen** check yes. If the child is a **legal immigrant**, provide the child's INS #, country of birth and the date the child entered the U.S. Children who are legal residents **may** qualify for these health insurance programs. You must provide a copy of the front and back of the child's Resident Alien Card or other proof of immigration status with this application. This information is for our records only and will not affect the immigration status of your children and will not be shared with the INS. We do not need information on the immigration status of any adults in your family. The INS cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you.

Unless you are applying solely for emergency medical services for a non-citizen child, a **Social Security Number** is required for all children

applying for health insurance. If the child does not have a Social Security Number, you must provide proof that you have applied for one for the child.

Tell us if the child is currently **attending school**.

Enter the correct code number for the **Race** of each child. Codes are listed below the question on the application. Then check yes or no if the child is of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus but may affect eligibility for FAMIS. Tell us if your children have health **insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless there was a "good cause" **reason why the health insurance ended**. Tell us if each child had health insurance during the past **4 months**. If they did, tell us about the policy and the date it ended. Read the good cause reasons listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, put #7 for "Other" and write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation of the good cause reasons or more information on what to include with the application, call **1-866-87-FAMIS** or your **local Department of Social Services**. **This rule does not apply to FAMIS Plus.**

Step 4 Income information: For each parent, stepparent and child under age 21 who lives in the home and receives income, list their **name** and the **source of the income**. If the income is from a job, list the name of the employer. If the income is from another source, (such as child support, unemployment compensation, Social Security, etc.) write the type or source of the income. Check if the person works for the **State of Virginia** or for a **local government agency**.

For each type of income listed, write the **amount of income** received and how often it is received (**each week, every two weeks, twice a month, once a month or yearly**). Be sure to write the amount of income before any taxes or other deductions are taken out (gross income).

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were

applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To prove income from a job, please attach a copy of all paycheck stubs for last month showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much the employee was paid for each pay period last month or you may call 1-866-87-FAMIS to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or business records for last month.

You must also provide proof of other types of income received. Examples of proof of other income include: Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, or a signed statement from the absent parent stating how much they pay each month; Social Security (SSA or SSI) — the current year award letter from the Social Security Administration; unemployment compensation — a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call 1-866-87-FAMIS or your local Department of Social Services.

Permission to contact employers: In some situations we may need to contact employers to get information about earnings. If you agree to let us do this in order to process this application, check yes.

Step 5 Childcare Expenses: Certain childcare expenses may help a child qualify for FAMIS Plus. Tell us if you **pay for childcare while you work**. If the answer is yes, write the **name** of each child in paid childcare and how much you pay for their childcare and how often you pay it. (For example, \$50 a week or \$200 a month.) You can even report this expense if you are paying a relative to care for the children. Also, report payments you make for adult daycare for an adult in your home that needs special care while you work.

Step 6 Medical Bills: If a child qualifies for FAMIS Plus, you may be able to get help with the child's **medical and dental bills for the past 3 months**. Tell us if a child applying for insurance has any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or children who have medical bills and the **month** in which the child or children received the medical or dental service. You will also have to show proof of family income for that month so we can determine if the child or children would have qualified for FAMIS Plus at the time the medical care was received. If a child qualifies for FAMIS instead of FAMIS Plus, medical bills will only be covered from the first day of the month in which your signed application was received by FAMIS or at the local Department of Social Services. **DO NOT SEND MEDICAL OR DENTAL BILLS TO FAMIS OR FAMIS Plus**. If the child qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the child during that time. We cannot pay for bills sent from individuals.

Step 7 RELEASE: If someone has helped you with this application or you would like someone else to be able to receive information about this application on your behalf, **clearly print the person's name** or the name of an **organization** in this section. We will not release any information about this application to anyone except you, unless you tell us here who you want to be able to receive this information.

Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application**. We cannot process an unsigned application.

Final checklist: Did you answer all the questions?
 Did you attach proof of all of last month's income?
 Did you attach any other necessary documents?
 Did you sign the application?

Mail or fax to FAMIS or your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES

(Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law and I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects my child(ren)'s eligibility for or receipt of FAMIS or FAMIS Plus (formerly Medicaid) insurance, including timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole basis for the action is lack of funding for FAMIS.
- Receive services from the Division of Child Support Enforcement and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus.

I further understand and agree that:

- This application could lead to my child(ren)'s enrollment in either FAMIS **OR** FAMIS Plus and that my child will be enrolled in the appropriate program based on eligibility rules.
- My children are not eligible for FAMIS coverage if they are eligible for FAMIS Plus, if they are eligible for health coverage under the Commonwealth of Virginia's State Employee Health Insurance Plan, or if they are patients in an institution for mental diseases. Children who are inmates in a public correctional institution are ineligible for both FAMIS and FAMIS Plus.
- The State and its contractors may contact other state and federal agencies to verify any information that affects my child(ren)'s eligibility for insurance.
- The State and its contractors may exchange information on this application

and medical, health, or other information relating to my child(ren)'s coverage with other agencies and contractors, including companies offering health insurance to my child(ren), to assist with application, enrollment, administration, quality control, and quality assurance. We will not share your information with the IRS or the INS.

- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by my child(ren).

- Each provider of medical services to my child(ren) may release any medical or other information necessary for the provider to be paid.

If my child is enrolled in FAMIS, I understand:

- I will be responsible for paying a **co-payment** for some FAMIS services received by my child(ren) and the FAMIS case will be maintained by the FAMIS Central Processing Unit (CPU).
- I have the responsibility to report within 10 days of the change, certain increases in income or changes in family size as explained in the FAMIS handbook and if the child enrolled in FAMIS moves out of the state of Virginia. I must report such changes to the FAMIS CPU at 1-866-873-2647.

If my child is enrolled in FAMIS Plus, I understand:

- That FAMIS Plus was formerly known as Medicaid. The FAMIS Plus case will be maintained by the local Department of Social Services where the child lives.
- I have the responsibility to report any changes in information provided on this form within 10 days of the change. I must report this information to the local Department of Social Services that maintains the child's FAMIS Plus case.

FAMIS AND FAMIS PLUS MUST BE RENEWED AT LEAST EVERY 12 MONTHS.

IT IS VERY IMPORTANT THAT YOU REPORT ANY CHANGE IN YOUR ADDRESS TO THE AGENCY THAT IS MANAGING THE CHILD'S CASE. IF WE DO NOT HAVE A CORRECT ADDRESS, WE WILL NOT BE ABLE TO NOTIFY YOU WHEN IT IS TIME TO RENEW COVERAGE AND THE CHILD WILL BE CANCELLED FROM THE PROGRAM.

HELP US KEEP YOUR CHILDREN COVERED — TELL US IF YOU MOVE!

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3. **Assignment of Rights and Pursuit of Support from Absent Parents** the assignment of rights to medical benefits requirements (M0250);
4. **Application for Other Benefits** the requirements regarding application for other benefits (M0270);
5. **Institutional Status** the institutional status requirements (M0280);
6. **HIPP** the application to the Health Insurance Premium Payment (HIPP) Program (M0290);
7. **Covered Group** the covered group requirements (chapter M03);
8. **Financial Eligibility** the asset transfer requirements (see subchapter M1450) apply.

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

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

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

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

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

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

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

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a caesarian delivery, DMAS must approve the coverage following the procedures in 2. below.

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

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

The verification must be documented in the record.

**2. DMAS
Certification
for Emergency
Services
Required**

When DMAS certification for emergency services is required, the worker must obtain a signed release of information from the applicant and request evidence of emergency treatment from the hospital and/or treating physician. If the hospital or treating physician wants to know what information is needed, refer the hospital's staff or physician (or physician's staff) to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

The worker must send the medical evidence to:

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

for a determination of medical emergency and the duration of the emergency services certification period. Use the Emergency Medical Certification, form #032-03-628 (see Appendix 4 of this subchapter) as a cover letter.

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

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

- A. Policy** An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.
- B. Application & Entitlement**
- 1. Application Processing** The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.
 - 2. Entitlement** If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.
 - 3. Spenddown** Spenddown provisions apply to medically needy individuals who have excess income.
 - 4. Notice** Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.
- C. Enrollment Procedures** Once a full benefit alien is found eligible for Medicaid, he must be enrolled on the Medicaid computer (MMIS) using the following data:
- 1. Cty** In this field, Country of Origin, enter the code of the alien's country of origin.
 - 2. CI** In this field, Citizenship code, enter the MMIS citizenship code that applies to the alien. Next to the MMIS code is the corresponding Alien Code from the Alien Code Chart in Appendix 3 to this subchapter. Eligible alien codes are:
 - R = refugee (Alien Chart codes F1, F2, G1, G2).
 - E = entrant (Alien Chart code D1).
 - P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
 - I = grandfathered aliens only (Alien Chart codes X1, X2, X3, Y1, Y2, Y3)
 - 3. Entry date** **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
 - 4. App Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
 - 5. Covered Dates Begin** In this field, coverage begin date, enter the date the alien's Medicaid entitlement begins.

6. **Covered Dates End** Enter data in this field only if eligibility *is a* closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.
7. **PD (AC)** Enter the code applicable to the alien's covered group.

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

A. Policy Unqualified aliens, and qualified aliens eligible for emergency services only (*see M220.500*), are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

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

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

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

C. Enrollment Procedures Once an emergency services alien is found eligible for *coverage of emergency services*, he must be enrolled on the Medicaid computer using the following data:

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

2. **CI** In this field, Citizenship code, enter :

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

D = *Emergency services alien who receives dialysis.*

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

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

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

- 3. Entry date** **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
- 4. App Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
- 5. Covered Dates Begin** In this field, coverage begin date, enter the begin date of the emergency service(s).
- 6. Covered Dates End** In this field, coverage end date, enter the date the alien's emergency service(s) ends.
- 7. PD (AC)** Enter the code applicable to the alien's covered group.

D. Notices

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

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

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

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If physical care, guidance or maintenance are not provided by the absent parent, parental functioning is considered interrupted or terminated; deprivation based on continued absence exists.

As permitted under federal regulations, eligibility based on continued absence from the home shall continue for a period not to exceed two months after the parent who has been absent returns to the home, provided the parent cannot make arrangements for supporting the family immediately after return.

An interruption or termination of parental functioning is documented when the parent/caretaker completes the section regarding the provision of maintenance physical care and guidance by the absent parent on the "Application for Benefits", the "Eligibility Review Part A" or the "ADAPT Statement of Facts

5. Physical or Mental Incapacity of Parent

A child is deprived of parental support or care if either parent has a physical or mental defect, illness or disability, and that incapacity substantially reduces the parent's ability to provide support or care, or prevents the parent from providing support or care. Incapacity may be total or partial, permanent or temporary, but must be expected to last for a period of at least 30 consecutive days. The 30-day minimum duration can begin prior to application for assistance if the incapacity is medically verified as beginning prior to application.

In making the determination of ability to support, the agency must take into account the limited employment opportunities of handicapped individuals. For the purposes of determining deprivation, a handicapped individual means any person who has a physical or mental impairment that results in a substantial detriment to employment. The applicant/recipient must establish the existence of an impairment that substantially limits employment opportunities.

a. Verification

Incapacity must be supported by a professional determination. The "Medical Report for General Relief, Medicaid and Temporary Assistance for Needy Families" (Form #032-03-039) or other professional documentation of incapacity is used for this purpose. Other documentation must state the diagnosis, prognosis, duration of incapacity, and specific activity limitations. If the individual is eligible for SSA, Railroad Retirement, or SSI due to disability or blindness, or has been found disabled by the MDU, he/she is incapacitated.

Cost of an examination necessary to determine incapacity (including transportation needed by the applicant) is payable, as charged, from administrative funds.

b. Continuing Deprivation Due to Incapacity

If the parent's incapacity is not subject to change, deprivation due to incapacity continues. If the incapacity is temporary, another examination and statement from the physician must be secured at the expiration of the time when recovery was anticipated in order to determine whether deprivation due to incapacity continues.

As permitted under federal regulations, deprivation due to incapacity shall continue for a period not to exceed two months following termination of the incapacity, as determined by the physician's statement, provided the parent cannot make immediate arrangements for supporting his family.

EXAMPLE #1: Mr. R fractured his leg February 10 and was unable to work. Mr. and Mrs. R and their two children ages 8 and 10 lived on accumulated savings until the savings were depleted in May. The family filed an application for Medicaid on May 25. Mr. and Mrs. R are not aged, blind or disabled, and Mrs. R is not pregnant. To determine their eligibility as caretakers of deprived dependent children, the agency requested medical verification of Mr. R's incapacity. The medical provided by his doctor indicated full recovery by June 15. Deprivation due to incapacity exists as of February 10 and continues for two months following termination of the incapacity if he remains unemployed and cannot support the family.

**6. Unemployment/
Underemployment
(UP) of LIFC
Parent**

Children living in two-parent families can be deprived of parental support due to the unemployment or underemployment (UP) of a parent(s). When the child is deprived because of parental unemployment or underemployment, each parent meets the definition of a "parent of a deprived, dependent child." The procedures for determining deprivation due to unemployment/ underemployment of a parent(s) for LIFC are different depending on whether the family participates in the Virginia Initiative for Employment not Welfare (VIEW).

For the LIFC covered group, deprivation due to the unemployment or underemployment of one or both parents is determined by comparing all of the UP deprivation unit's countable earned and unearned income to the F&C 90% income limit (see M0710, Appendix 3). If the unit's income is within these limits, then the child(ren) is deprived because of the parents' unemployment or underemployment.

a. Determine the Deprivation Unit

Use the policy and procedures in section M0310.111 C. 1. to determine the deprivation unit.

b. Determine the Unit’s Countable Income

Use the policy and procedures in chapter M07 to determine the unit’s gross and countable income.

c. Compare Income to the Income Standards

1) Non-VIEW

Compare the unit’s total gross income to the LIFC 185% standard of need (see M0710, Appendix 1), then compare countable income to the F&C 90% income limit (see M0710, Appendix 3).

If the unit’s income exceeds the LIFC 185% standard of need or the F&C 90% income limit, deprivation due to unemployment or underemployment does not exist.

If the unit’s income is less than or equal to the LIFC 185% standard of need or the F&C 90% income limit, the child(ren) is deprived due to unemployment or underemployment of the parents, and the parents and child(ren) meet the LIFC covered group.

Non-VIEW Example--Child Deprived Due to UP

EXAMPLE #2 (Using September 2000 figures): In September, Mrs. Jones applied for Medicaid for herself and everyone in her home. They live in Group I. The household consists of Mrs. Jones, Mr. Jones, her spouse, and their 8 year old son. Mr. and Mrs. Jones are under age 65 and are not disabled, blind or pregnant. Mr. Jones works part-time and earns \$355 per month. Mrs. Jones and their child have no income. The child meets the MI child covered group. The only covered group the parents can meet is LIFC. To meet the LIFC covered group, Mr. and Mrs. Jones must be parents of a dependent, deprived child. Because their child lives with both parents, the child must be deprived of parental support due to his parents’ unemployment or underemployment. The parents’ unemployment or underemployment is determined:

deprivation unit = Mr. and Mrs. Jones, and their son.

\$355	Mr. Jones’ gross earnings
<u>-546</u>	185% standard in Group I for 3 persons
0	excess; passed 185% screen

\$355	Mr. Jones' earnings
<u>- 90</u>	work exclusion
265	countable earnings
<u>- 265</u>	90% income limit for Group I for 3 persons
0	excess; passed 90% screen

The unit's countable income is equal to the F&C 90% income limit. Therefore, the child is deprived due to the unemployment or underemployment of his parents and the parents meet the definition of "parents of a dependent, deprived child." Mr. and Mrs. Jones and their child meet the LIFC covered group (the child also meets the MI child covered group). Their financial eligibility is determined using the family/budget unit policy in chapter M05 and the income policy in chapter M07.

Non-VIEW Example--Child NOT Deprived Due to UP

EXAMPLE #3 (Using September 2000 figures): In September, Mrs. Green applied for Medicaid for herself and everyone in her home. They live in Group I. The household consists of Mrs. Green, Mr. Green, her spouse, their 10 year old son, Mike, and Mrs. Green's 15 year old daughter, Sara, from her first marriage. Mr. and Mrs. Green are under age 65 and are not disabled, blind or pregnant. Mr. Green works part-time and earns \$355 per month. Mrs. Green and Mike have no income. Sara receives \$650 per month child support from her absent father.

Mike and Sara meet the MI child covered group. The only covered group the parents can meet is LIFC. To meet the LIFC covered group, Mr. and Mrs. Green must be parents of a dependent, deprived child. Because their child lives with both parents and neither parent is incapacitated, the child can only be deprived of parental support due to his parents' unemployment or underemployment. The parents' unemployment or underemployment is determined:

deprivation unit = Mr. and Mrs. Green, Mike (their 10 year old son) and Sara (Mrs. Green's 15 year old daughter).

\$355	Mr. Green's gross earnings
<u>+650</u>	Sara's child support
1005	total gross income
<u>-662</u>	185% standard in Group I for 4 persons
343	excess; failed 185% screen

The unit's gross income exceeds the LIFC 185% standard of need. Therefore, the child is NOT deprived due to the unemployment or underemployment of his parents and the parents DO NOT meet the definition of "parents of a dependent, deprived child." Mr. Green is not eligible for Medicaid because he does not meet a Medicaid covered group.

However, Mrs. Green is a parent of a dependent child who is deprived of parental support due to the absence of the child's father. Her financial eligibility and the financial eligibility of the MI children are determined using the family/budget unit policy in chapter M05 and the income policy in chapter M07. If Mrs. Green's budget unit's countable income is within the LIFC 185% standard of need and F&C 90% income limit, then she will be eligible for Medicaid in the LIFC covered group.

2) VIEW Participants

Compare the unit's total gross earned income to the 100% Federal Poverty Limit (FPL) (see subchapter M0710, Appendix 6, 2nd chart). If the total gross earned income is greater than 100% FPL, UP deprivation does not exist. Evaluate the family members for eligibility in other covered groups.

If the unit's gross earned income is less than or equal to 100% FPL, then compare the unit's unearned income to the F&C 90% income limit. If the unearned income is greater than the F&C 90% income limit, UP deprivation does not exist. Evaluate the family members for eligibility in other covered groups.

If the unearned income is less than the F&C 90% income limit, the child(ren) is deprived due to UP, and the parents and child(ren) meet the Medicaid requirements for the LIFC recipients covered group.

VIEW Example--Child Deprived Due to UP

EXAMPLE #4 (Using February 2000 figures): In September Mrs. Dylan, a VIEW participant, reports a change in income. The deprivation unit consists of Mrs. Dylan, Mr. Dylan, her spouse, and their 8 year old son. Mr. Dylan works and earns \$1,055 per month. Mrs. Dylan receives \$200 unemployment compensation per month. Their child has no income. They live in Group I. Because their children live with both parents and neither parent is disabled, UP deprivation must be determined:

Deprivation unit = Mr. and Mrs. Dylan, and their 8 year old son.

\$1055	Mr. Dylan's gross earnings
<u>-1179</u>	100% FPL
0	excess earnings; passed gross earned income screen

\$265	90% F&C income limit for Group I for 3 persons
<u>-200</u>	unearned income from unemployment compensation
65	deficit

The unit's gross earned income is less than the 100% FPL and their unearned income is less than the F&C 90% *income limit*. Therefore, the child is deprived due to UP and the parents meet the definition of "parents of a dependent, deprived child."

VIEW Example--Child not Deprived Due to UP

EXAMPLE #5 (Using February 2000 figures): On September 4th, Mrs. Stem, a *VIEW participant*, reported she and her husband, Mr. Stem, started new jobs earning \$250 per week. The *deprivation* unit consists of Mrs. Stem, Mr. Stem, their 8 year old son, and their 4 year-old daughter. They have no unearned income. They live in Group III. Because their children live with both parents and neither parent is disabled, deprivation due to UP must be determined:

Deprivation unit = Mr. and Mrs. Stem, their 8 year old son and their 4 year old daughter.

\$1,075	Mr. Stem's gross earnings
+1,075	Mrs. Stem's gross earnings
2,150	total gross earnings
-1,421	100% FPL for 4 person unit
729	excess earnings; failed the 100% FPL screen

The deprivation unit's gross earned income exceeds 100% FPL. Therefore, the children are not deprived due to UP and the parents do not meet the definition of "parents of a dependent, deprived child." Evaluate the family members for eligibility in other covered groups prior to canceling Medicaid coverage.

D. Procedures-- Living With Relative of Specified Degree

1. Relationship

To verify the child's relationship to the caretaker, 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
- marriage records
- court support and/or divorce records which clearly identify the relationship of the caretaker-relative to the child.

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 F&C income limit 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.

- B. Procedure** The individual must elect hospice care in a non-institutional setting. Election of hospice care is verified either verbally or in writing from the hospice care provider. If verification is verbal, document the case record.

M0310.117 INSTITUTION

- A. Definition** An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.
- B. Medical Institution (Facility)** A **medical institution** is an institution that:
- is organized to provide medical care, including nursing and convalescent care,
 - has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
 - is authorized under state law to provide medical care, and
 - is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.
- C. Procedures** The procedures used to determine if an individual meets a covered group of individuals in institutions are contained in subchapters M0320 and M0330.

M0310.118 LIFC

- A. Low Income Families with Children (LIFC)** Low Income Families with Children (LIFC) is a covered group of individuals in families who have a dependent, deprived child(ren) living in the home, and whose income is within the Medicaid F&C income limits.
- B. Procedure** Section M0320.306 contains the detailed requirements for the LIFC covered group.

M0310.119 MEDICALLY INDIGENT (MI)

- A. Definition** "MI" is the short name for "medically indigent." MI is the name Virginia uses for the subclassification of federally mandated categorically needy covered groups that do not receive cash assistance and that have income within a percentage of the federal poverty income guidelines.
- An MI individual is one who is not eligible for cash assistance, but who meets the requirements of an MI covered group and has income within the specified percentage of the federal poverty limit.

- B. Procedure** The procedures used to determine if an individual meets an MI covered group are in subchapter M0320.

M0310.120 MEDICALLY NEEDED (MN)

- A. Definition** "MN" is the short name for "medically needy." MN is one of the two federal classifications of Medicaid covered groups. All medically needy covered groups are optional; the state can choose whether or not to cover medically needy individuals in its state plan. However, if the state chooses to cover medically needy individuals, it must at least cover children under age 18, pregnant women and the protected group of individuals who were eligible as medically needy blind or disabled in December 1973 and continue to meet the December 1973 eligibility criteria. The state may choose to cover additional groups of individuals as medically needy.

The medically needy individual is one who has income and resources enough to meet his maintenance needs, but not enough to meet his medical needs. He is not eligible for a cash assistance payment because his income and/or resources exceed the cash assistance limits. Medically needy individuals whose income exceeds the MN income limit may become eligible as MN by incurring medical and/or remedial care expenses to establish eligibility (spenddown).

- B. Procedure** The procedures used to determine if an individual meets a medically needy covered group are in subchapter M0330.

M0310.121 MEDICARE BENEFICIARY

- A. Definition** A Medicare beneficiary is an individual who is entitled to Medicare (Title XVIII of the Social Security Act). Medicare is a federally funded and administered health insurance program and consists of hospital insurance protection (Part A) and medical insurance protection (Part B).

- 1. Part A** A person is entitled to Medicare Part A if he/she

a. is age 65 or older and:

- eligible for monthly Social Security benefits on the basis of covered work under the Social Security Act,
- a qualified railroad retirement beneficiary,
- not eligible for social security or railroad retirement benefits but meets the requirements of a special transitional provision,
- not eligible for social security or railroad retirement benefits but voluntarily enrolls and pays a monthly premium, or

**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

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

M0310.134 VIEW PARTICIPANT

A Virginia Initiative for Employment not Welfare (VIEW) participant is an individual who has signed the TANF Agreement of Personal Responsibility. VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

M0310.133 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.

C. Financial Eligibility

- 1. Asset Transfer** The individual must meet the asset transfer policy in subchapter M1450.
- 2. Assistance Unit** The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.
- 3. Resources** The resource limit is \$2,000 for an individual and \$3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.
- 4. Income** The income limits are \leq 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.
- 5. Income Exceeds
80% FPL** **Spendedown does not apply** to this covered group. If the individual's income exceeds the 80% FPL limit, he/she is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

- 1. Begin Date** Eligibility in the ABD 80% FPL covered group cannot begin earlier than July 1, 2001. If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month, but no earlier than July 1, 2001.
- 2. Retroactive
Entitlement** ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period, but no earlier than July 1, 2001.

E. Enrollment

The program designations are:

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

M0320.300 FAMILIES & CHILDREN CATEGORICALLY NEEDY**A. Introduction**

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman definition in M0310, or BCCPTA definition in M0310.

The F&C CN covered groups are divided into the medically indigent (MI), CN and CNNMP classifications. First determine if the F&C individual meets an MI covered group. If the individual does not meet an MI covered group, then determine if the individual meets the requirements of an F&C CN or CNNMP covered group.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C MI, CN or CNNMP covered group are contained in the following sections:

- M0320.301 MI Pregnant Women & Newborn Children;
- M0320.302 Family Planning Services (*FPS*);
- M0320.303 MI Child Under Age 19 (*FAMIS Plus*);
- M0320.305 IV-E Foster Care or IV-E Adoption Assistance Recipients;
- M0320.306 Low Income Families With Children (LIFC);
- M0320.307 Individuals Under Age 21;
- M0320.308 Special Medical Needs Adoption Assistance;
- M0320.309 F&C In Medical Institution, Income \leq 300% SSI;
- M0320.310 F&C Receiving Waiver Services (CBC);
- M0320.311 F&C Hospice;
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

M0320.301 MI PREGNANT WOMEN & NEWBORN CHILDREN**A. Policy**

The federal Medicaid law requires the Medicaid State Plan to cover pregnant women and newborn children whose family income is within 133% of the federal poverty limit. The law allows the State Plan to cover these pregnant women and newborns regardless of their resources; Virginia has chosen to waive the resource eligibility requirements for this covered group.

B. Nonfinancial Eligibility**1. Pregnant Woman**

42 CFR 435.170 - The woman must meet the pregnant woman definition in M0310.124.

The MI pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

2. Newborn Child

42 CFR 435.117 - A child born to a mother who was Medicaid-eligible as CN, CNNMP, or MI at the time the child was born is eligible as CNNMP as a newborn child under age 1 year. The child remains eligible for Medicaid so long as the mother remains eligible, or would be eligible if she were pregnant, for Medicaid and they live together.

pregnancy and the 60-day period following the end of her pregnancy. Medicaid coverage ends the last day of the month in which the 60th day occurs.

E. Enrollment

The PD (program designation) for MI pregnant women is “91”.

The PD for MI newborns is “93”.

M0320.302 FAMILY PLANNING SERVICES (FPS)

A. Policy

Chapter 899 of the 2002 Acts of Assembly, Item 325 M, directs DMAS to provide payment for Family Planning Services (FPS). *Effective October 1, 2002, women who receive a pregnancy-related service paid for by Medicaid may receive up to 24 months of family planning services following the end of their pregnancy. Since women enrolled in the MI Pregnant Woman covered group receive 60 days of postpartum coverage with full Medicaid benefits, they are eligible to receive 22 months of family planning services following the end of their pregnancy and the 60-day postpartum period. For women who received a pregnancy-related service paid for by Medicaid for the period October 1, 2002 through September 30, 2003, an eligibility determination must be completed. These women must continue to meet the income requirements of the MI Pregnant Woman covered group to be enrolled in the FPS covered group.*

Effective October 1, 2003, women eligible in the MI Pregnant Woman covered group who receive a pregnancy-related service paid for by Medicaid on or after October 1, 2003, are eligible for the FPS covered group following the end of the 60-day postpartum period; an eligibility determination is not required. Changes in income do not affect eligibility for 12 months following the end of the pregnancy. A redetermination of eligibility must be completed 12 months after the date the pregnancy ended. If the woman remains eligible, she is entitled to an additional 12 months of FPS coverage.

Women who received a pregnancy-related service paid for by Medicaid and were enrolled in a covered group other than MI Pregnant Women may be eligible for the FPS covered group if their income is less than or equal to 133% FPL. These women are subject to an eligibility determination.

Eligibility in the FPS covered group can extend no longer than the 24th month following the end of the pregnancy.

Retroactive coverage is available for FPS.

B. Nonfinancial Requirements

Women in this covered group must be ineligible to receive full coverage under Medicaid and must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status (emergency services aliens described in M0220.700 are not eligible); Virginia residency;
- Social Security number;
- assignment of rights to medical benefits;
- application for other benefits; and
- institutional status.

Women who meet the requirements for a full benefit Medicaid covered group are not eligible for this covered group. Medicaid recipients who were not enrolled in Medicaid as a MI pregnant woman (PD 91) or as a MN pregnant woman (PD 97) must provide proof of the pregnancy in order to meet this covered group. DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for the FPS covered group.

C. Financial Eligibility

1. **Assistance Unit** Use the assistance unit policy in chapter M05 to determine the FPS financial eligibility.
2. **Asset Transfer** The asset transfer rules do not apply to the FPS covered group.
3. **Resources** There is no resource limit.
4. **Income** The income requirements in chapter M07 must be met for the FPS covered group. The income limits are 133% of the FPL and are found in subchapter M710, Appendix 6.

An income eligibility determination is not required for women enrolled in the MI Pregnant Women covered group who received a Medicaid covered pregnancy-related service on or after October 1, 2003. They are deemed to be income eligible for FPS for the first 12 months following the end of their pregnancy. These women must be determined income eligible to receive FPS for the second 12 months following the end of the pregnancy.

An income eligibility determination is required for:

- *women enrolled in the MI Pregnant Women covered group who received a Medicaid covered pregnancy-related service whose pregnancy ended on or after October 1, 2002, but prior to October 1, 2003; and*
- *women who were not enrolled in the MI Pregnant Women covered group before their pregnancy ended but who received a Medicaid covered pregnancy-related service on or after October 1, 2002.*

5. **Spenddown** Spenddown does not apply to this covered group.

D. Entitlement and Enrollment

Eligibility in the FPS covered group can extend no longer than the 24th month following the end of the pregnancy.

The eligibility worker must cancel the MI Pregnant Women enrollment effective the last day of the month of the 60-day postpartum period and enroll the woman in FPS the first day of the following month. An eligibility determination is not required for those MI Pregnant Women whose pregnancy ends on or after October 1, 2003.

Women who were not enrolled in the MI Pregnant Women covered group who had a Medicaid covered pregnancy-related service must have an eligibility determination. If the woman does not meet a covered group entitled to full Medicaid benefits, but meets the requirements of the FPS covered group she is to be enrolled in FPS.

The PD for FPS is “80”.

Written notice must be sent to inform the recipient of her eligibility in the FPS covered group and of the reduction in coverage. She must also be advised of the opportunity to receive a redetermination of eligibility for full coverage.

The eligibility worker must code the special review field in the MMIS with FPMDDCCYY (family planning, month, day, century and year the pregnancy ended). When this special review code is used, the MMIS will automatically send the advance notice and cancel FPS coverage 24 months after the pregnancy ends.

The MMIS will cancel this coverage using reason code “36”.

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.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, *provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.*

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.
- D. 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.

and parents or caretaker-relatives of dependent children who participate in the Virginia Initiative for Employment not Welfare (VIEW) component of the Virginia Independence Program (VIP) and meet the requirements of the 1115 waiver. This covered group is called “Low Income Families With Children (LIFC).

B. Nonfinancial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02.

The child(ren) must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child’s parent or must meet the definition of a caretaker-relative of a dependent child in M0310.107. A child or adult who lives in the household but who is not the dependent child’s parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in M0310.113.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in subchapter M0520 applies to the LIFC covered group. The assistance unit’s financial eligibility is determined first. If the family unit has resources or income that cannot be verified or that exceeds the amount for the individual’s covered group, the family unit is divided into budget units, if appropriate.

If the LIFC individual is living with his/her spouse or child who is aged, blind, or disabled, two different financial calculations must be completed for the unit if the family unit does not meet the LIFC resource and income limits, because of the different resource and income rules and the different resource and income limits used in the F&C and ABD determinations.

2. Asset Transfer

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

3. Resources

There is no resource test for the LIFC covered group.

4. Income**a. Non-View Participants**

The income requirements in chapter M07 must be met by the LIFC group. The income limits are in M0710.002.

b. View Participants

The income requirements in chapter M07 must be met by VIEW participants. The method for determining income eligibility is different for VIEW participants and is found in M0710.730 D. The income limits are in M0710.002.

5. Income Exceeds CNNMP Limit

Spenddown does not apply to the CNNMP income limits. If the family/budget unit's (FU/BU's) income exceeds the F&C CNNMP income limit, the unit is not eligible as CNNMP LIFC and cannot spenddown to the CNNMP limit. If resources are within the medically needy limit, the unit may be placed on spenddown if at least one member meets an MN covered group, such as MN children under age 18.

D. Entitlement

Entitlement to Medicaid as an LIFC individual begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

E. Enrollment

The PD (program designation) for individuals in the LIFC covered group are:

- 81 for LIFC individual;
- 83 for LIFC-UP individuals.

M0320.307 INDIVIDUALS UNDER AGE 21**A. Policy**

42 CFR 435.222 - The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the resource and income requirements of the state's July 16, 1996 AFDC State Plan. These reasonable classifications of individuals under age 21 are:

- individuals in foster homes, private institutions or independent living arrangements for whom a public agency is assuming full or partial financial responsibility;

NOTE: A foster care child in a non-custodial agreement who is in an independent living situation meets this requirement and is eligible in this covered group;

- individuals placed in foster homes or private institutions by private nonprofit child placing agencies;

b. Adoptive Placement

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

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

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

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

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

3. Resources *There is no resource test for the Individuals Under Age 21 covered group.*

4. Income The income limits and requirements are found in chapter M07.

Adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

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

D. Entitlement & Enrollment

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The PD (program designation) for individuals in the CNNMP covered group of individuals under age 21 are:

- 76 for a non-IV-E foster care child;
- 72 for a non-IV-E adoption assistance child;
- 75 for a Juvenile Justice Department child;
- 82 for a child in nursing facility or ICF-MR.

M0320.308 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

A. Policy

42 CFR 435.227 - The federal Medicaid law allows the State Plan to cover an individual under age 21 years

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the covered group of "special medical needs adoption assistance children."

B. Nonfinancial Eligibility

The child must

- be under age 21,
- meet the "special medical needs" adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility

- 1. Assistance Unit** The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the adoption assistance child's own income and resources are counted.
- 2. Asset Transfer** The asset transfer rules in subchapter M1450 must be met by the child.
- 3. Resources** *There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.*
- 4. Income** Adoption assistance children in residential facilities do not have a different income limit. The CNNMP income limit (F&C 100% income limit) for one person in the child's locality is used to determine eligibility as categorically needy non-money payment. For an adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality which signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the CNNMP income limit, evaluate the child in the medically needy covered group of "special medical needs adoption assistance" in subchapter M0330.

D. Entitlement & Enrollment

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The PD for individuals in the CNNMP covered group of special medical needs adoption assistance children is "72."

M0320.309 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI**A. Policy**

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

- meet the Medicaid resource requirements; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020.

3. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the individual is married and institutionalized, use the resource policy in *subchapter M1480*.

a. Resources Within The Limit

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

b. Resources Exceed The Limit

If the individual is not eligible because of excess resources and she has Medicare Part A, determine if she meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. See M0320.206 through 208 for the ABD MI covered groups.

If the woman's resources are NOT within the limit, she is NOT eligible for Medicaid.

4. Income

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see M0710, Appendix 5 for the MN income limits).

5. Income Changes After Eligibility Established

Any changes in a medically needy pregnant woman's income that occur after her eligibility has been established, **do not** affect her eligibility as long as she meets the pregnant woman definition, the nonfinancial and MN resource eligibility requirements, and she meets the following conditions:

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

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

6. Example--PG Woman Applies Before Pregnancy Ends

EXAMPLE #1: A married pregnant woman applies for Medicaid on October 10. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning \$1,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible

for retroactive coverage effective July 1. Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition, or she no longer meets other nonfinancial or resource eligibility requirements.

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

EXAMPLE #2: (using April 2003 figures)

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

**8. Income Exceeds
MN Limit**

Because the MN pregnant woman's income exceeds the MI limit, it also exceeds the MN limit. She becomes eligible in this MN covered group when she has incurred medical expenses equal to the difference between her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

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

If she has Medicare Part A, determine if she meets a medically indigent (MI) ABD covered group because the MI ABD income limits are higher than the MN limits. See sections M0320.206 through 208 for the ABD MI covered groups.

C. Entitlement

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met, and ending the last day of the month in which the 60th day occurs or the spenddown period ends, whichever comes first. Retroactive coverage is applicable to this covered group.

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.

4. Pregnant Woman

An individual who meets the pregnant woman definition is counted as at least **two persons** when her eligibility is being determined in the MI Pregnant Woman or MN Pregnant Woman covered group. The unborn child (or children, if medical documentation verifies more than one fetus) must be included in the unit with the pregnant woman when determining her eligibility. A separate calculation is required for the other family unit members who do not meet a pregnant woman covered group. This calculation does NOT include the unborn child(ren) as part of the family unit and/or budget unit (*BU*).

When an individual is pregnant but her eligibility is determined in a covered group other than MI or MN Pregnant Woman, such as blind, disabled or Low Income Families with Children (LIFC), the pregnant woman is counted as just one person.

5. Cohabitant

A cohabitant is not the child(ren)'s parent and is not legally responsible for anyone in the family unit. Therefore, the cohabitant is not included in the family unit. Do not *count* a cohabitant's income or resources.

C. Examples

1. Household With Excluded Child

EXAMPLE #1: Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. *The family unit consists of:*

- *the applicant*
- *her husband, and*
- *her 15-year old son.*

The family unit's income is determined using the F&C income policy and procedures.

**2. Household
With
Acknowledged
Father**

EXAMPLE #2: *Household listed on the Medicaid application consists of pregnant woman applicant, her 5-year old son and her boyfriend, who is the acknowledged father of the 5-year old. They all request Medicaid.*

The family unit for the Medicaid eligibility determination for the 5-year old child, and the acknowledged father consists of:

- *the woman,*
- *the 5-year old child and*
- *the child's acknowledged father.*

The family unit for the Medicaid eligibility determination for the pregnant woman consists of:

- *the pregnant woman,*
- *her unborn child,*
- *the 5-year old child, and*
- *the child's acknowledged father.*

The family unit's income is determined using the F&C income policy and procedures.

M0520.101 MULTIPLE FAMILY UNITS

A. Policy

Multiple family units exist in a household in the following situations:

**1. Non-parent
Caretaker**

When the individual is applying for Medicaid as a non-parent caretaker of a deprived dependent child, multiple family units exist.

**2. EWB
(Essential to
the Well-
Being)**

When the individual is applying for Medicaid as an individual who is EWB to family with a deprived dependent child, multiple family units exist.

**3. Child--No
Responsible
Relative In
Home**

When the individual applying is a child under age 21 but has no responsible relative living in the household and is not a sibling of another child(ren) in the household, multiple family units exist.

**4. Adult--No
Responsible
Relative In
Home**

When the individual applying is age 21 or older and is not legally responsible for the other applicant(s) in the household, multiple family units exist.

**5. Foster Care
Child**

When the individual applying is a foster care child whose parent(s) live in the household and who is placed in his/her home for a trial visit (see M0520.701 below), multiple family units exist.

6. Siblings

Siblings under age 21 are included in the same family unit.

B. Procedures

When an applicant applies for a child in the household, begin forming the family unit by identifying the child(ren) who applies and meets an F&C covered group. Divide the household into multiple family units when:

- the household contains an individual(s) who applies for Medicaid but who is not a legally responsible relative of the other individual(s) who has applied; or
- the household contains a foster care child under age 21 who is placed in the home for a trial visit.

Each family unit must contain only those individuals among whom legal responsibility for support exists.

M0520.102 NON PARENT CARETAKER IN HOUSEHOLD

A. Policy

An individual who is not the parent of a dependent child who lives in the household, but who meets the definition of a caretaker-relative (subchapter M0310) is called a “non-parent caretaker.” Only one **non-parent** caretaker in a household can meet the LIFC covered group. An individual cannot meet the caretaker-relative definition when the child’s parent lives in the household.

A non-parent caretaker is in a family unit that is separate from the dependent child(ren) for whom the individual is a caretaker-relative.

B. Family Unit Composition

To determine the non-parent caretaker-relative’s family unit, identify the non-parent caretaker-relative who requests Medicaid and meets the LIFC covered group. Include the caretaker-relative’s spouse and/or the caretaker-relative’s children under age 21 who live in the household in the family unit with the non-parent caretaker-relative. The dependent, deprived child(ren) is in a separate family unit.

C. Determine Income Eligibility

Add together all of the countable income received by the members of the non-parent caretaker-relative’s family unit. Compare the total countable income to the LIFC 185% and F&C 90% income limits.

If the family unit’s income is within the F&C 185% and the 90% limits, the non-parent caretaker-relative is eligible as LIFC. Also, the children under age 18 (or under age 19 if in school) and the spouse in the non-parent caretaker-relative’s family unit are eligible regardless of her status as a non-parent caretaker-relative of another deprived child, because her family unit meets the LIFC Med-UP covered group. Her child(ren) is deprived because of the unemployment or underemployment of the parents, due to income being less than the limits.

If the family unit’s income exceeds the *LIFC* income limits, determine if the family unit can be broken into BUs units to test the BUs’ income against the LIFC limits. See M0520.200 below. If the family unit cannot be broken into BUs, the non-parent caretaker-relative is not eligible for Medicaid as LIFC because of excess income.

D. Examples--Non-Parent Caretaker-Relative Family Units

EXAMPLE #3: Household listed on application consists of applicant (aunt), her 10-year old niece, and her 8-year old nephew, who is not a sibling of the niece. She is their legal guardian and she requests Medicaid for herself and the children.

The household consists of three family units:

1. *the 8-year old nephew, who has no legally responsible relatives or siblings living in the household;*
2. *the niece, who has no legally responsible relatives or siblings living in the household; and*
3. *the aunt.*

The financial eligibility for each family unit is determined using F&C financial policy and procedures and comparing the result to the limits for the covered group(s) for which eligibility is being determined. If each child's countable income is within the MI child income limits for an assistance unit of 1, each child is income eligible. If the aunt's countable income is within the F&C limits for the locality, the aunt is income eligible for the LIFC covered group.

EXAMPLE #4: Household listed on application consists of woman applicant (aunt), her husband (uncle), their 15-year old son, their 10-year-old niece, and their 8-year old nephew who is not a sibling of the niece. They all request Medicaid.

The household consists of three family units:

1. *the 8-year old nephew, who has no legally responsible relatives or siblings living in the household;*
2. *the 10-year old niece, who has no legally responsible relatives or siblings living in the household; and*
3. *the aunt, uncle, and their son.*

The financial eligibility for each family unit is determined using F&C financial policy and procedures and comparing the result to the limits for the covered group(s) for which eligibility is being determined. If the nephew's and niece's countable income is within the MI child income limits for an assistance unit of 1, each child is income eligible. If the aunt, uncle, and their son's countable income is within the F&C limits for the locality, the aunt, uncle, and their son are income eligible for the LIFC covered group. Their son is also income eligible for the MI child covered group.

M0520.103 EWB IN HOUSEHOLD

A. Policy When the household includes an individual who applies for Medicaid who meets the definition of an EWB in subchapter M0310, and the person to whom the EWB provides essential services meets the nonfinancial and income requirements for Medicaid in the LIFC covered group, the EWB is in a separate family unit. An EWB does not exist if the family to whom he/she provides essential services is not eligible for Medicaid as LIFC.

The EWB's financial eligibility for Medicaid is determined by using the income of the EWB's family unit members only. The income of the individual to whom he/she is providing essential services is NOT counted because that individual is not legally responsible for the EWB, nor is the EWB legally responsible for the individual.

B. Family Unit Composition To determine the EWB's family unit, start with the EWB who requests Medicaid and meets the LIFC covered group as an EWB. Include the EWB's spouse and/or the EWB's children under age 21 who live in the household. The dependent, deprived child(ren) and the caretaker for whom the EWB is providing essential services are in a separate family unit(s).

C. Determine Income Eligibility Add together all of the countable income received by the members of the EWB's family unit. Compare the total countable income to the LIFC 185% and F&C 90% income limits.

If the EWB's family unit's income is within the F&C 185% and 90% limits, the EWB is eligible as LIFC, if the family to whom the EWB provides essential services is eligible as LIFC.

If the EWB's family unit's income exceeds the LIFC limit, determine if the family unit can be broken into BUs to test the BUs' income against the limits. See M0520.200 below. If the EWB's family unit cannot be broken into BUs, the EWB is not eligible for Medicaid as LIFC because of excess income.

D. Example--EWB In Household **EXAMPLE #5:** Household listed on application consists of an applicant mother, her 6-year old son and her 20-year old niece. They all request Medicaid. Her niece takes care of her son while the mother works. The niece meets the definition of an EWB because she provides child care which enables the mother to work full time.

Because the niece is an EWB, the household contains multiple family units:

- 1. the 6-year old son and his mother; and*
- 2. the EWB niece, who has no legally responsible relatives in the household.*

*The mother and son's family unit's income is determined using the F&C income policy and procedures. If their countable income is within the MI income limit for 2 persons, the son is eligible in the MI child covered group. If their countable income is **within** the LIFC income limit for 2 persons, the mother is eligible for Medicaid as LIFC, and her niece meets the LIFC covered group as an EWB. Because the niece has no income, she is eligible for Medicaid as an LIFC EWB.*

*If the mother's family unit income **exceeds** the LIFC limit, the mother is not eligible for Medicaid because of excess income. She cannot be placed on a spenddown because she does not meet a medically needy covered group. The niece is not eligible for Medicaid because the mother is not eligible as LIFC and the niece does not meet a Medicaid covered group.*

M0520.200 BUDGET UNIT RULES

A. Policy

BUs are formed to assure that only the individual's resources and income and the resources and income of those persons legally responsible for the individual are used to determine the individual's Medicaid financial eligibility. If the individual's family unit has resources or income which cannot be verified or which exceed the limit for the individual's covered group, determine if the family unit can be broken into BU. *Forming BUs based on resources is only applicable to the F&C MN covered groups.* A family unit must be broken into BUs when:

1. a child in the family unit has his/her own income;
2. a child in the family unit has his/her own resources (*applicable only for F&C MN covered groups*);
3. the child's stepparent is in the family unit;
4. the child's parent with whom he/she lives is a Medicaid minor (under age 21) and they live with the minor parent's parent(s);
5. the child is married and living with his/her spouse and his/her parent(s);
6. the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

All members of a family unit must be placed in a BU when the family unit can be divided into BUs. Although they will be included in a BU, persons found eligible at the family unit level do NOT have their eligibility redetermined at the BU level.

- B. Budget Unit Rules** The rules that apply to BU composition are:
- 1. Member In One Unit** An applicant/recipient can be a member of only one F&C BU.
 - 2. Children With Own Resources (F&C MN Only) or Income**

The child(ren) with his or her own resources or income is in a separate BU. Deem resources and income from parents. *Resources are deemed and/or counted only when determining eligibility for F&C MN covered groups.*

The parent(s) is/are included in the unit with child(ren) who has no resources or income.

If all of the children have resources or income, the parent(s) is/are in a separate BU. If there is more than one child with resources or income, the resources or income deemed from the parents are divided evenly among the children.
 - 3. Medicaid Minor Caretaker Applicant**

When the Medicaid minor parent is not married and lives with his/her parent(s), he or she is included in a BU with his/her parent(s), NOT with his or her child(ren).

When the Medicaid minor parent is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse.

A married Medicaid minor parent is in a separate BU when living with his/her spouse and the minor's parent(s).
 - 4. Married Medicaid Minor**

When the Medicaid minor is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse. A married Medicaid minor is in a separate BU when living with his/her spouse and the minor's parent(s).
 - 5. Stepparent In Household**

A stepparent is not included in a BU with his/her stepchild(ren). A married parent (except a Medicaid minor parent who lives with his/her parents) is included in a BU with his/her spouse and their child(ren)-in-common. The parent's other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.
 - 6. Deeming From Parents**

When determining how much of the child's parent's income or *resources* are deemed available to the child's BU, any income or *resources* deemed to the parent from the parent's spouse who is not the child's parent, is NOT counted in the deeming calculation.

No income or resources deemed from the parent(s) of a minor child are deemed to the minor child's spouse or the minor's child.
 - 7. Acknowledged Father**

An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

8. Spenddown Expenses

If a BU is ineligible because of excess income, only the unit's member's medical expenses will count toward the unit's spenddown, unless a BU member is legally liable to pay the medical expenses of another person in the household, whether or not that other person is in another Medicaid BU. If a BU member is legally liable for another person in the household, the other person's medical bills can count toward the BU member's spenddown.

A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses can be deducted from the parent's spenddown. If the child's unit's spenddown is met, then the child's medical expenses that were not used to meet the child's spenddown can be deducted from the parent's spenddown, if the medical expenses are not covered by Medicaid or other health insurance.

M0520.201 CHILD(REN) WITH RESOURCES AND/OR INCOME

A. Policy

The child(ren) with his or her own resources (*F&C MN covered groups only*) or income is in a separate BU. *Forming BUs based on resources is only applicable to F&C MN covered groups.* Deem income and resources from the parents *if the child is living with the parents*; and from the child's spouse if the child is married and living with the spouse.

B. Forming Budget Units

Place the child who has his/her own resources or income in a BU by himself.

EXAMPLE #6: Household listed on application consists of woman applicant, her disabled spouse, their 15-year old son, and their 20-year old daughter. *They all request Medicaid.*

The family unit consists of:

- the mother,
- her husband, and
- their two children under age 21.

The family unit's LIFC income is then determined using the F&C income policy and procedures.

Because the family unit's income exceeds the LIFC income limit for 4 persons and the son *receives unearned income from a trust fund*, the family unit is broken into BUs:

- BU #1 = son
- BU #2 = mother, her husband, and their daughter

The parent's BU's countable income is calculated to determine the parents' eligibility as LIFC and to determine how much income is deemed to the son's BU. The parent's deemed income is added to the son's income to determine the son's BU's countable income for eligibility in the MI child covered group.

M0520.202 MARRIED MEDICAID MINOR OR MEDICAID MINOR CARETAKER LIVING WITH PARENT

A. Policy

The Medicaid minor parent (caretaker) is included in a BU with his/her parent(s), NOT with his or her child(ren), unless the Medicaid minor caretaker has resources (*F&C MN covered groups only*) or income of his/her own, or is married and living with his/her spouse.

If the Medicaid minor parent (caretaker) has resources or income, or is married and living with a parent(s) and his/her spouse, place the Medicaid minor caretaker in a BU by himself/herself and deem the parents' resources and income (and the spouse's resources and income, when the Medicaid minor caretaker is married and living with his/her spouse) to the Medicaid minor caretaker.

B. Forming Budget Units

1. Medicaid Minor Caretaker

Place the Medicaid minor parent caretaker in a BU with his/her parents when the Medicaid minor parent:

- is not married, or is married but not living with his/her spouse, and
- has no resources or income of his/her own.

EXAMPLE #7: Household listed on application consists of woman applicant, her disabled spouse, their 17-year old daughter and her 2-year old son (woman's grandson). They all request Medicaid.

The family unit consists of:

- *the mother,*
- *her husband,*
- *their daughter, and*
- *the daughter's son.*

The family unit's income is determined using the F&C income policy and procedures. Because the family unit's income exceeds the LIFC and MI child's income limit for 4 persons and daughter is a Medicaid minor parent, the family unit is broken into BUs:

- BU #1 = 2-year old grandson
- BU #2 = the mother, her husband and the 17-year old Medicaid minor parent

The mother and her husband's countable income is calculated to determine their eligibility as LIFC and the Medicaid minor parent's eligibility as MI. Because the Medicaid minor parent has no income of her own, there is no income to deem to her son's BU.

2. Married Medicaid Minor

Place the married Medicaid minor in a BU by himself/herself when the Medicaid minor:

- is married and living with his/her spouse, *or*
- has resources or income of his/her own, *AND*
- lives with his/her parent(s).

Deem a portion of the married Medicaid minor's parent's resources and income to the married minor, and deem a portion of the married minor's spouse's resources and income to the married minor.

EXAMPLE #8: Household listed on application consists of the married Medicaid minor applicant age 17, her spouse age 25 and her parents. They all request Medicaid.

The family unit consists of:

- *the married Medicaid minor,*
- *her husband, and*
- *her parents.*

The family unit's income is determined using the F&C income policy and procedures. The family unit's income exceeds the LIFC and the MI income limits for 4 persons.

Because the daughter is a married Medicaid minor *who lives with her parents and her spouse*, the family unit is broken into BUs:

- BU #1 = the married Medicaid minor
- BU #2 = her husband
- BU #3 = her parents

The parent's BU's countable income is calculated to determine the parents' eligibility as LIFC and to determine the amount deemed to the married Medicaid minor. Her husband's countable income is calculated to determine the amount deemed to the married Medicaid minor. The income deemed from the married Medicaid minor's parents and the income deemed from her husband are added to the married Medicaid minor's income to determine her total countable income.

**3. Medicaid
Minor Parent
Caretaker
Has
Resources
(F&C MN
Only) or
Income**

Place the Medicaid minor parent caretaker in a BU by himself/herself when the Medicaid minor caretaker has resources or income of his/her own.

EXAMPLE #9: Household listed on application consists of woman applicant, her spouse, their 17-year old daughter and the 17-year old's 2-year old son. They all apply for Medicaid.

The family unit consists of:

- *the mother,*
- *her husband,*
- *their daughter, and*
- *their daughter's 2-year old son.*

The family unit's income is determined using the F&C income policy and procedures. Because the family unit's income exceeds the LIFC and MI income limits for 4 persons, the mother and father are not eligible in the LIFC covered group, and the daughter and her child are not eligible as MI.

Because the Medicaid minor parent caretaker has unearned income from a trust fund, the family unit is broken into BUs:

- BU #1 = the 2-year old
- BU #2 = the Medicaid minor parent
- BU #3 = the mother and father of the minor parent

The mother and father's BU's countable income is calculated to determine their eligibility and to determine the amount of income to deem to their daughter.

The Medicaid minor parent's BU's countable income is first calculated to determine her income. Her income then is added to the amount of income deemed from her parents to determine her eligibility. A separate calculation must be done to determine the amount of the Medicaid minor parent's own income (not including income deemed from her parents) that must be deemed to her 2-year old.

The 2-year old's BU's countable income is the amount of income deemed from his mother since he has no other source of income.

M0520.203 STEPPARENT IN HOUSEHOLD

A. Policy

A stepparent is in a BU separate from his/her stepchild(ren). A married parent (except a minor married parent) is included in a BU with his/her spouse and their child(ren)-in-common. The parent's(s') other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.

Deem resources and income from the parent to his/her child's BU. Do not deem any of the stepparent's resources or income to the parent's child.

B. Forming Budget Units

Place a married parent in a BU that is separate from the parent's child(ren); include the married parent's spouse (the child's stepparent) in the BU with the parent. Include the parent's and stepparent's child(ren)-in-common in the BU with the parent and stepparent.

EXAMPLE #10: Household listed on application consists of mother, her spouse, their 6-year old son, and her 8-year old son from another relationship. They all request Medicaid.

The family unit consists of:

- the mother,
- her 8-year old son,
- her spouse (stepparent to her son), and
- their 6-year old son.

The family unit's income is determined using the F&C income policy and procedures. The family unit's countable income is within the MI income limit, so the children are eligible as MI children. The family unit's income exceeds the LIFC 185% screen, so the unit is not eligible for LIFC Medicaid at the family unit level because of excess income.

BUs are allowed because there is a stepparent in the home:

- BU #1 = 8-year old child
- BU #2 = mother, stepparent, their 6-year old child

BU #2's income is calculated and screened at the LIFC 185% of need. Because the mother and her spouse's BU's income exceeds the LIFC 185% income screen, they are not eligible as LIFC and cannot be placed on a spenddown because they do not meet a medically needy covered group.

M0520.204 ACKNOWLEDGED FATHER IN HOUSEHOLD

A. Policy

An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

The mother's own children (who are not the acknowledged father's children) are included in a BU with the mother (unless the child(ren) has resources or income of his/her own).

B. *Forming Budget Units*

When an acknowledged father lives in the household and is not married to the child(ren)'s mother, place the child(ren) and *the acknowledged father* in separate BUs.

EXAMPLE #11: Household listed on application consists of mother, her boyfriend who is the acknowledged father of their 4-year old son, their 4-year old son and her 8-year old daughter. They all request Medicaid.

The family unit consists of:

- the mother,
- her 8-year old daughter,
- the acknowledged father, and
- their 4-year old son.

The family unit's gross income exceeds the income limits for the LIFC and MI child covered groups. Because there is an acknowledged father, BUs are formed:

BU #1 = mother, her 8-year old child

BU #2 = their 4-year old child

BU #3 = acknowledged father

M0520.300 DEEMING FROM SPOUSE

A. Policy

The spouse is included in the F&C spouse's budget unit UNLESS:

- the spouse is an SSI or IV-E recipient (do NOT deem any resources or income from an SSI or IV-E recipient spouse to the F&C spouse);

- the F&C spouse is a Medicaid minor parent and they are living with his/her parent(s);
- the F&C spouse's spouse is under age 21 and they are living with the spouse's parent(s).

**B. SSI or IV-E
Recipient Spouse**

*If eligibility is being determined in an F&C covered group that has a resource test, the income and resources owned **solely** by an SSI or IV-E recipient are not considered available to his/her spouse. The pro-rata share of resources owned **jointly** by the F&C spouse and his/her SSI or IV-E recipient spouse is counted available to the F&C spouse when they are living together.*

When **not** living together, resources owned jointly with the SSI or IV-E recipient are available only if the SSI or IV-E recipient agrees to sell or liquidate the resource. If the SSI or IV-E recipient agrees, then only 1/2 of the resource's value is counted as available to the F&C spouse.

**C. Married Medicaid
Minor Living
With Parents**

Determine how much of the deemor spouse's resources (*F&C MN covered groups only*) and income to deem to the F&C spouse (Medicaid minor) using the following procedures:

**1. Deem
Resources**

a. Determine Countable Resources

Determine the value of the deemor spouse's countable resources owned solely and jointly, according to policy in chapter M06.

b. Subtract Resource Deeming Standard

From the total of the deemor spouse's share of jointly held resources and resources held in his/her name only, subtract the \$1,000 resource deeming standard.

c. Deem Remaining Resources

The remaining value, if any, is deemed available to the F&C spouse.

d. Deeming Does Not Reduce Resources

If any of the deemor spouse's resources that are over the resource limit are deemed, this does not make the spouse resource-eligible. Deeming resources does not reduce the deemor's countable resources.

2. Deem Income

To determine how much of the deemor spouse's income to deem to the F&C spouse, use the following procedures:

a. Determine Countable Income

Determine the deemor spouse's gross monthly countable unearned and earned income according to chapter M07.

b. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section M0720.500:

- Standard work exclusion of \$90 (M0720.520), and
- Child/incapacitated adult care exclusion (M0720.540).

Do NOT subtract the \$30 plus 1/3 or \$30 earned income exclusions.

c. Subtract Deeming Standard

Subtract the deeming standard. The deeming standard is the F&C 100% income limit for the locality for

- the number of persons in the deemor spouse's BU, **plus**
- the number of deemor's child(ren) under age 21 in the household who are excluded from the Medicaid application (are not included in **any** Medicaid BU) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year.

See M0710, Appendix 3, for the F&C 100% income limit.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

d. Subtract Support Payments Made

Subtract actual support paid to individuals NOT in the home, who are or could be claimed as dependents on the **deemor's** federal tax return.

Subtract actual alimony and/or child support payments made to individuals NOT in the home and not claimed as dependents on the **deemor's** federal income tax return.

e. Deem Remainder

Deem the remaining balance to the eligible F&C spouse (plus the spouse's F&C child(ren), if any, who is not in the spouse's BU) as unearned income.

NOTE: Deeming income does not reduce the deemor's countable income *for his Medicaid eligibility determination.*

**D. Example--
Married Minor
Living With
Parents**

EXAMPLE #12: (Using 1999 figures)

A Medicaid minor pregnant woman lives with her husband, their 1-year old child, his 14-year old child from a previous marriage, and her parents. They apply for everyone except her parents. They live in Group I. Her husband earns \$3,200 monthly. She has no income. She and her husband own a joint savings account with a balance of \$1,600. Her father earns \$2,000 monthly; her mother has no income.

1. Family Unit

The Medicaid minor pregnant woman's family unit consists of herself, her unborn child, her husband, their 1-year old child, his 14-year old child, and her parents (a family unit of 7).

\$3,200	husband's earnings
<u>+2,000</u>	PG woman's father's earnings
5,200	total earnings
<u>- 180</u>	2 standard work exclusions (\$90 x 2 = 180)
5,020	countable income
<u>- 2,789</u>	MI pregnant woman income limit for 7 persons
2,231	excess

The family unit's countable income exceeds the MI pregnant woman income limit for 7 persons, so the pregnant woman is not eligible for Medicaid as MI at the family unit level.

2. Budget Units

Because there is a Medicaid minor parent and a stepparent in the household, the family unit is divided into BUs:

- BU #1 = the minor PG woman *and unborn child* (2);
- BU #2 = her spouse, their 1-year old child (2);
- BU #3 = her spouse's 14-year old child (1);
- BU #4 = her parents (2).

Due to excess income at the BU level, a MN eligibility determination is required. Portions of her spouse's resources (for F&C MN only) and income are deemed to her BU according to the spouse deeming procedures.

BU #1 spouse deeming calculations:

a. Resource Deeming

\$ 800 husband's 1/2 of joint savings
-1,000 resource deeming standard
 0 excess (no resources deemed to F&C spouse)

b. Income Deeming

\$3,200 husband's earnings
- 90 standard work exclusion
 3,110 countable income
- 229 deeming standard for deemor's BU (2 persons in Group I)
 2,881 excess
÷ 2 PG woman (spouse) and 14-year-old child
 \$1,440.50 deemed to each

The parents' deemed resources and income to the pregnant woman's BU are calculated according to M0520.400 below. The parents' deemed income is added to the spouse's deemed income to determine the minor PG woman's income eligibility.

M0520.400 DEEMING FROM PARENT

A. Policy

A parent's resources (F&C MN only) and income are considered available (either counted in the unit or deemed) to a child under age 21 living with a parent. The parent's resources and income are deemed to the child when the child is in a separate BU from the parent, unless

- the parent is an SSI recipient or has a 1619b status,
- the parent receives IV-E foster care or adoption assistance,
- the child is living away from home per M0520.001 B.3, or
- the child is a foster care child placed in the home for a trial visit of 3 months or less.

1. Deeming Standard

The deeming standard is the portion of the parent's countable resources or income that is not considered available to the child who is in a separate BU from the parent. The resource deeming standard is \$1,000. The income deeming standard is the locality F&C 100% income limit for the deemor parent's BU plus any excluded children.

- 2. Single Parent or Parent and Stepparent with No Child in Common** When each child in the home has only one parent in the home and the parent is in a separate BU, subtract the whole deeming standard from the parent's countable resources and income.
- Note: A stepparent is not a "parent" for deeming purposes.
- 3. Both Parents In Same BU-Married With Child in Common**
- a. No Stepchildren**
- When both parents (at least one child in common) are in the same BU and there are no stepchildren, subtract the whole deeming standard from the parents' resources and income.
- b. Stepchildren**
- When both parents (at least one child in common) are in the same BU and there are stepchildren in the home, subtract one-half of the deeming standard for the parents' BU from deemor parent's resources and income.
- 4. Both Parents In Different BUs** When both parents (at least one child in common) are in separate BUs, subtract the whole deeming standard from the deemor parent's countable resources and income.
- B. Deeming Resources (F&C MN Only)**
- 1. Determine Countable Resources** Determine the value of countable resources owned solely by the parent and the value of countable resources owned jointly with the parent's spouse or another person, according to policy in chapter M06. All resources that are in the deemor parent's name only plus the deemor's share of jointly held resources are counted.
- 2. Subtract Resource Deeming Standard**
- a. Single Parent or Parent and Stepparent with No Child in Common**
- Subtract the whole resource deeming standard of \$1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).
- Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.
- b. Both Parents In Same BU With Child in Common**
- 1) Subtract the whole deeming standard of \$1,000 from the parents' countable resources when there are children in common and no stepchildren in the home.
- When both parents are deeming only to children in common, their resources are combined and only one deeming calculation is done.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU (including her child in common with her husband)

\$ 800.00	Mom's earnings
<u>- 90.00</u>	standard work exclusion
710.00	countable income
<u>- 156.63</u>	½ deeming standard for 3 in Group I (\$313.25)
553.37	deemable income
<u>÷ 2</u>	number of her children not in her BU
\$ 276.69	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child and their child in common

\$2,200.00	Dad's earnings
<u>- 90.00</u>	standard work exclusion
2,110.00	countable income
<u>- 156.63</u>	½ deeming standard for 3 in Group I (\$313.25)
\$1,953.37	deemable income

c. BU #1

\$1,953.37 countable income (deemed from Dad) exceeds MI child limit for BU of 1 and child is placed on a MN spenddown.

d. BUs #2 and #3

\$ 276.69	deemed unearned income from Mom
+ 150.00	child's own income
<u>- 50.00</u>	child support disregard
376.69	countable income is within MI child limit for both BUs of 1

e. BU #4

\$2,200	husband's earnings
+ 800	woman's earnings
<u>- 180</u>	2 standard work exclusions (\$90 x 2 = 180)
2,820	countable earned income exceeds LIFC income limit

M0520.500 CHANGES IN STATUS**A. Policy**

When the household composition changes, or the circumstances of the household members change, the F&C family and budget unit may change, and the requirements to deem a spouse's or parent's resources (*F&C MN only*) and income may change.

- B. Procedure** See M0520.501 for Family/Budget Unit Changes.
See M0520.502 for Deeming Changes.

M0520.501 FAMILY/BUDGET UNIT CHANGES

- A. Introduction** Some changes in the household composition which require changes in the family unit or budget units are listed and described in this section.
- B. Spouses Separate or Divorce** If a married F&C individual and his/her spouse separate or divorce and no longer live together, the spouse is not included in the F&C individual's family or budget unit beginning the month after the month in which the separation or the divorce occurred. If a married F&C individual and his/her spouse divorce but they remain living in the same household, the divorced father is considered an acknowledged father beginning the month after the month in which the divorce occurred.
- C. Individual Begins Living With A Spouse** For applicants, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month in which they begin living together.
- For recipients, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month after the month they begin living together.
- D. Parent and Child Begin Living in Same Household** For applicants, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month in which they begin living together.
- For recipients, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month **after** the month they begin living together.
- NOTE: A newborn child is considered living with the parent(s) as of the date the child is born, unless the child is entrusted into foster care on that date.
- E. Spouse or Parent Dies** If a spouse or parent dies, the spouse or parent is deleted from the family or budget unit effective with the month following the month of death.
- F. Individual Becomes Institutionalized** If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, the individual is a separate family unit effective with the first month in which the individual is institutionalized.
- G. Individual Leaves Home** If an F&C individual leaves the household, the individual is deleted from the family or budget unit beginning with the month following the month in which he left the household.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

- H. Child Attains Age 21** Effective the month following the month in which a child attains age 21, the child is removed from the family or budget unit. An individual attains age 21 on the day preceding the anniversary of his/her birth.

M0520.502 DEEMING CHANGES

- A. Introduction** Some changes in the circumstances of the household members which require changes in the deeming procedures are listed and described in this section.
- B. Spouses Separate or Divorce** If a married F&C individual and his/her spouse separate or divorce and no longer live together, or their marriage ends in divorce but they remain living in the same household, the spouse's resources (*F&C MN only*) and income are not deemed to the F&C spouse's family or budget unit beginning the month after the month in which the separation or the divorce occurred. The divorced father who lives in the household with his child(ren) and ex-wife is treated like an acknowledged father.
- NOTE: If an application is filed in the month of separation or divorce, deeming applies that month even if the application is filed on or after the date of separation or divorce.
- C. Individual Begins Living With A Spouse** If an F&C individual begins living with a spouse, deeming of the spouse's resources (*F&C MN only*) and income to the F&C spouse's BU begins effective with the month after the month they begin living together.
- D. Spouse Or Parent Dies** If a spouse or parent dies, deeming stops for purposes of determining eligibility effective with the month following the month of death. If the child lives with two parents and one dies, deeming continues from the surviving parent to determine eligibility.
- E. Individual Becomes Institutionalized** If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, deeming stops for purposes of determining eligibility effective with the first month in which the individual is institutionalized.
- F. Individual Leaves Home** If a spouse, parent or child no longer live in the same household, deeming of that spouse's or parent's resources (*F&C MN only*) and income stops effective the month after the month the spouse, parent or child leaves the household for purposes of determining eligibility, except for a foster care child. When a child is removed from the home and placed in foster care, the child becomes an FU of 1 person effective the date of commitment or entrustment or non-custodial foster care agreement. The child is deleted from the family's FU effective the end of the month during which the child was placed in foster care.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

G. Parent and Child Begin Living in Same Household

If an F&C child begins living with a parent in the same household (e.g., a newborn child comes home from a hospital), the parent's income is deemed to the child's BU for purposes of determining eligibility beginning the month after the month they begin living together.

H. Child Attains Age 21

Deeming stops effective the month following the month in which a child attains age 21. An individual attains age 21 on the day preceding the anniversary of his/her birth. Eligibility is determined using only the individual's own income after the child attains age 21. The individual's income for the current month and subsequent months must include any income in the form of cash provided by the parents.

M0520.600 PREGNANT WOMAN BUDGET UNIT

A. Policy

A pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus.

The other members of the household who are included in the pregnant woman's family or budget unit depend on whether the pregnant woman is under age 21 years, is married and is living with her parent(s) or spouse.

B. Budget Unit

The BU includes her spouse who lives with her unless the spouse receives SSI, or she and/or her spouse are Medicaid minors living with her or his parent(s).

The BU also includes her child(ren) under age 21 living in the home unless:

- the child(ren) has his or her (their) own income (child is separate BU);
- she specifically excludes the child(ren);
- the child(ren)'s acknowledged father is living in the home and is not married to the pregnant woman;
- she is a Medicaid minor and lives with her parent(s);
- she is a married Medicaid minor and lives with her spouse and parent(s); or
- she is married and living with her spouse who is not the father of the child(ren). If she is married, living with her spouse who is not the father of her child(ren), and she does not exclude her child(ren) under

age 21 living in the home, the child(ren) is a separate BU and the pregnant woman's own income and resources deemed available to the child.

M0520.601 UNMARRIED PG WOMAN OVER AGE 21 BUDGET UNIT

A. Policy

An unmarried pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus. It includes her minor child(ren) under age 21 who live with her unless

- the child has his/her own resource (*F&C MN only*) or income,
- the child's acknowledged father lives in the home, or
- she excludes the child.

B. Example-- Unmarried PG Woman Over Age 21

EXAMPLE #15: (Using 2/15/00 figures) Group II locality. An unmarried pregnant woman age 25 applies for Medicaid for herself and her 10-year old child. She lives with her parents, her 20 year old brother and her 10-year old child. They have no resources. She earns \$1,200 per month and her 10-year old child receives \$200 monthly child support from his father. Her family unit consists of herself (*pregnant woman counts as two persons for her eligibility*) and her 10-year old, 3 persons. *The 10-year child's family unit consists of the 10-year old and his mother, 2 persons.*

\$1,200	PG woman's earnings
- 90	standard work exclusion
1,110	countable earnings

\$ 200	monthly child support
- 50	support disregard
150	countable unearned
+1,110	countable earned
1,260	countable monthly income

The pregnant woman's family unit's income is less than the MI pregnant woman's income limit so she is eligible as an MI pregnant woman.

M0520.602 MARRIED PG WOMAN BUDGET UNIT

- A. Policy** A married pregnant woman's BU includes her spouse with whom she lives, unless
- she is under age 21 and they live with her parent(s),
 - her spouse is under age 21 and they live with his parent(s),
 - she has a minor child(ren) living in the household who is not her spouse's child, or
 - her spouse has a minor child(ren) living in the household who is not the PG woman's child.
- 1. PG Woman Is Medicaid Minor Living With Her Parents** When the married PG woman is a Medicaid minor (under age 21 years old) and they live with her parent(s), the BU consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified). Her spouse and their child(ren) are in a separate BU.
- 2. PG Woman's Spouse Is Medicaid Minor Living With Spouse's Parents** When the married PG woman's spouse is a Medicaid minor and they live with her spouse's parent(s), the BU consists of the pregnant woman, the unborn child(ren) and their child(ren)-in-common, if any. Her Medicaid minor spouse is in a separate BU and her spouse's parents are in a separate BU.
- 3. PG Woman And/Or Spouse Have Other Children** When the married PG woman and/or her spouse are age 21 or older, or are under age 21 but do not live with either's parent(s), and have other children in the household who are not their children-in-common, the BU consists of the pregnant woman, her unborn child(ren) and her spouse. Her child(ren) is in a separate BU and his child(ren) is in a separate BU.
- B. Example—Married PG Woman Over Age 21, Other Children In Household** **EXAMPLE #16:** A Medicaid application is filed for a pregnant woman and everyone in her family. She lives with her husband who is not aged, blind, or disabled, her 10-year old child by a former marriage, and his 15-year old child from a former marriage. They have no resources. The family unit's income exceeds the MI pregnant woman income limit for 5 persons, the MI child income limit for 4 persons, and the LIFC 185% standard of need for 4 persons, so BUs are formed because there is a stepparent in the household. Three BUs exist:
- BU #1 = the pregnant woman, her unborn child, and her husband (3);
 - BU #2 = her husband's 15-year old child (1);
 - BU #3 = her 10-year old child (1).

M0520.700 INDIVIDUAL UNDER AGE 21 FAMILY UNIT**A. Policy**

The family unit of an individual who meets the covered group of “individuals under age 21 who are in foster care, adoption assistance or in ICF/ICF-MR care” is determined using the family unit rules in M0520.100 above when the individual lives with a parent or spouse. If the individual does not live with a parent or spouse, the individual is in a family unit by himself.

If the individual under age 21 is living away from home, see M0520.001 B.3. to determine if the individual is considered living with his/her parents.

B. Procedure

The following sections contain the policy and procedures to use when determining the family/budget unit of an individual under age 21:

- M0520.701 Foster Care Child Family Unit;
- M0520.702 Non IV-E Adoption Assistance Family Unit;
- M0520.703 Special Medical Needs Adoption Assistance Child Family Unit;
- M0520.704 Child In ICF or ICF-MR.

M0520.701 FOSTER CARE CHILD FAMILY UNIT**A. Policy**

A foster care child who is not living with his/her parents is a family unit of one person. A child in foster care who is not living with his or her parent(s) is evaluated as a separate family unit, even if the child is living with his or her own siblings in foster care. When a child is removed from his/her home and placed in foster care, the child becomes a family unit of 1 person effective the date of the commitment or entrustment to, or non-custodial agreement with the agency.

1. Child Living With Parents

If the foster child is living with his or her parents and/or siblings NOT on a trial visit basis, the foster care child is included in the family unit with his/her parents and siblings.

If the child’s family unit has resources (*F&C MN only*) or income which exceeds the limit for the child’s covered group, determine if the family unit can be broken into BUs. The foster care child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources (*F&C MN only*);
- the child has his/her own income;

- the child's stepparent is in the family unit;
- the child's parent with whom he/she lives is a minor (under age 21) and they live with the minor parent's parent(s);
- the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

**2. Child Placed
In Own Home
For Trial Visit**

A foster care child who is placed in the home with his/her parents and siblings **for a trial visit** is a separate family unit of 1 person. The parent(s)' resources and income are NOT deemed available to the foster care child. Verify the trial visit with the agency's Child Welfare Services staff.

The trial visit is no longer than three months for this section's purposes. A child will continue to be a single person BU during a trial visit and only the child's income and resources will be counted in determining the child's Medicaid eligibility.

**3. Foster Care
Payment Is
Excluded**

The foster care payment is excluded when determining the family unit's financial eligibility.

B. Examples

1. Trial Visit

EXAMPLE #19: The agency services staff places the foster care child, age 10, with his family for a trial visit. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of 2 family units:

- family unit #1 = foster care child (1);
- family unit #2 = foster care child's parents, 13-year old sister (3).

**2. Home
Placement,
Not Trial Visit**

EXAMPLE #20: The agency services staff places the foster care child, age 10, with his family. This is NOT a trial visit, but the agency retains custody of the child. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of one family unit: the foster care child, his parents and his 13-year old sister (4).

M0520.702 NON IV-E ADOPTION ASSISTANCE CHILD FAMILY UNIT

A. Policy

A non IV-E adoption assistance child who is not living with his/her parents is a family unit of one person.

**1. Child Living
With Parent(s)**

A non IV-E adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit from placement until the interlocutory or final order of adoption, whichever comes first. The adoptive parents' resources and income are NOT deemed available to the adoption

assistance child until the interlocutory or final order of adoption, whichever comes first, is entered.

After the interlocutory or final order of adoption, whichever comes first, a non IV-E adoption assistance child who is living with his or her parent(s) is included in a the family unit with his/her parent(s). If the family unit has resources (*F&C MN only*) or income which exceeds the limit for the child's covered group, determine if the family unit can be broken into BUs. The non IV-E adoption assistance child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources (*F&C MN only*);
- the child has his/her own income;
- the child's stepparent is in the family unit.

2. Exclude Adoption Subsidy Payment

The adoption subsidy payment is excluded when determining the unit's financial eligibility.

B. Example –Child Placed With Adoptive Parents

EXAMPLE #21: Mary B. is a 19-year old *non IV-E foster care child* who is in the custody of the local social services agency. On August 5, 1997, she is placed with Mr. and Mrs. G who plan to adopt her. The adoption assistance agreement was signed on August 5, 1997. There is no interlocutory order and the final order will not be signed until February 1998. Mr. and Mrs. G have two children, Tom who is age 17 and Jane who is age 15. Mary receives \$575 per month SSA benefits from her deceased father's work record. Mr. G earns \$3,000 per month gross earnings. Mrs. G has no income of her own. Mary's continued Medicaid eligibility is determined:

Mary's family unit consists of Mary by herself because she does not live with any responsible relative. The final order of adoption will not be signed until February 1998. Beginning with the month following the month in which the final adoption order is signed. Mary will be in a family unit with her adoptive parents and siblings.

C. Example—Child Living With Adoptive Parents

EXAMPLE #22: John is a 20-year old *non IV-E adoption assistance child* who is in the custody of the local social services agency until August 5, 1997, when the final order of adoption was signed by the judge. His adoptive parents are Mr. and Mrs. T. The adoption assistance agreement was signed on September 15, 1996. Mr. and Mrs. T have two other children, George who is age 17 and Julie who is age 15. John receives \$250 per month adoption subsidy. Mr. T earns \$3,000 per month gross earnings. Mrs. T has no income of her own. John's continued Medicaid eligibility for September 1997 and subsequent months is determined:

John's family unit consists of himself, his adoptive parents and his two siblings, a family unit of 5 persons.

M0520.703 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILD FAMILY UNIT

- A. Policy** A non IV-E special medical needs adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit. **The adoptive parents' income is NOT deemed available to the special medical needs adoption assistance child at any time.**
- B. Exclude Adoption Subsidy Payment** The adoption subsidy payment is excluded when determining the child's financial eligibility.

M0520.704 CHILD IN ICF OR ICF-MR FAMILY UNIT

- A. Policy** When an individual under age 21 is in an intermediate care facility (ICF) (nursing facility) or ICF-MR (intermediate care facility for the mentally retarded) for 30 consecutive days or more, the child is institutionalized and is considered separated from his/her parents.
- Child in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.
- The child is a family unit of one person, regardless of the child's covered group. The parents' resources and income are **not** deemed available to the child. If the parents give the child any money, that money is counted as income according to the F&C income rules in chapter M07.

M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

M0610.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. *Most F&C categorically needy covered groups (see subchapter M0320) do not have resource requirements. Resource policy does not apply to the following categorically needy covered groups:*

- *MI Pregnant Women & Newborn Children;*
- *Family Planning Services;*
- *MI Child Under Age 19 (FAMIS Plus);*
- *IV-E Foster Care or IV-E Adoption Assistance Recipients;*
- *Low Income Families With Children (LIFC);*
- *Individuals Under Age 21;*
- *Special Medical Needs Adoption Assistance; and*
- *BCCPTA.*

This section addresses how to determine resource eligibility for the following:

- *F&C in Medical Institution, Income \leq 300% SSI;*
- *F&C Receiving Waiver(CBC) Services;*
- *F&C Hospice; and*
- *all F&C medically needy covered groups.*

All real and personal property legally owned by each member of the family unit/budget unit (FU/BU) is evaluated and the countable value is considered in determining Medicaid eligibility for the FU/BU.

Resources of each member of a FU/BU are evaluated using the rules in this chapter. Resource eligibility is determined by comparing the countable resources to the appropriate limit based on the composition of FU/BU. The policy governing the formation of the FU/BU is contained in M05.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the third month prior to the month in which the application is received.

2. Countable Resources

Any assets that are resources but are not specifically excluded by policy are countable resources. Only countable resources are used to determine resource eligibility. See:

- M0610.002 for the resource limits;
- M0610.100 for the distinction between assets and resources;
- M0630.100 for a listing of exclusions.

- 3. Whose Resources Must Count** Medicaid law requires that resources are only considered available between spouses and from parents to their children under age 21 who live at home.
- 4. Whose Resources Must Count** Medicaid law does not allow certain resources to be considered in determining eligibility. Do not count resources:
- from a step-parent to a step-child;
 - from siblings to siblings;
 - from child to parent;
 - from spouse or parent, living apart unless it is a voluntary financial contribution (Exception for long-term care, *see M1480*);
 - from an alien sponsor.
- 5. Total Countable Resources** The total value of the countable resources owned or deemed available to all FU members are counted in determining the resource eligibility of each FU member.
- The total value of the countable resources owned or deemed available to all BU members are counted in determining the resource eligibility of each BU member.
- 6. Resource Eligibility** If the total countable value of the FU/BU's countable resources are at or below the resource limit at any point during the application month, retroactive month, or a month in which the case is pending, resource eligibility exists for that month.
- 7. Excess Resources** After determining countable resources in accordance with B.2. through 5. above, if the family unit has resources other than the excluded items listed in M0630 totaling more than the allowable resource limit, determine if budget units can be formed. See Budget Unit rules in M0520. If BUs cannot be formed, or the BU's countable resources exceed the resource limit, resource eligibility does not exist.
- If the FU/BU has a real property resource, see M0630.105 and M0630.110 for reasonable effort to sell real property.
- 8. Income Not Resources** When determining the value of resources available to the family/budget unit, do not consider any income as a resource in the month in which it is received.

M0610.002 RESOURCE LIMITS

- A. Introduction** A separate resource limit is set for each Medicaid classification. A resource limit is the maximum dollar amount of countable resources a FU or BU may own and the individuals within that unit be eligible for Medicaid.

B. Policy Principles

1. Resource Eligibility

A FU or BU with countable resources equal to or less than the resource limit applicable to the individual’s covered group classification is resource eligible. A FU or BU with countable resources in excess of the limit applicable to the individual’s covered group classification is not eligible for Medicaid.

2. Resource Limits

F&C Classification	Limit
<i>Categorically Needy</i>	\$1000 for the FU or BU
Medically Needy	\$2000 for one person \$3000 for two persons and \$100 for each additional person in the FU or BU

M0610.100 DISTINCTION BETWEEN ASSETS AND RESOURCES

A. Introduction

Everything an individual owns is an asset. A resource is an asset the individual owns, has the right, authority, or power to convert to cash, and is not legally restricted from using for his/her support and maintenance. Changes in situations may result in an asset becoming a resource or a resource becoming an asset. The distinction is important as resources may affect Medicaid eligibility and assets that are not income or resources do not affect eligibility.

B. Definitions

1. Assets

Assets are all monies received and everything owned. An asset that is not income or a resource does not impact Medicaid eligibility.

EXAMPLE: An individual has an ownership interest in property but is not legally able to transfer that interest to anyone else. This ownership interest in the property is the individual’s asset but because he is legally restricted from selling it (converting it to cash), it is not a resource and it does not meet the definition of income. It remains an asset, but it is not counted in determining his financial eligibility.

2. Resources

Resources are cash and any other real and personal property that a member of the family or budget unit:

- owns;
- has the right, authority, or power to convert to cash (if not already cash); and
- is not legally restricted from using for his/her support and maintenance.

NOTE: A trust may be a countable resource even though the individual does not have the authority to convert it to cash or is legally restricted from using it. See subchapters M1120.200-202 and M1140.400-404 for policy and procedures specific to determine if a trust (other than one established by a will) is a resource.

3. **Countable Resources** Resources that are not specifically excluded by policy are countable resources.
4. **Real Property** Real property is land, including buildings or immovable objects attached permanently to the land. (See M620.150 for a mobile home that is taxed as real property.)
5. **Personal Property** Personal property is any property that is not real property. The term encompasses such things as cash, tools, farm and business equipment, life insurance policies, automobiles, and mobile homes taxed as personal property.
6. **Ownership** Ownership of property by an individual means that the individual has a clear legal entitlement to the property, real or personal, or a specific portion thereof.

C. Policy

1. **Sale or Trade of an Asset** Proceeds from the sale or trade of an asset must be evaluated as income in the month of receipt.
2. **Sale or Trade of a Resource** Proceeds from the sale or trade of a resource are also resources. The sale or trade of a resource is converting a resource from one form to another.
3. **Increased Value** Increases in the assessed or market value of a resource are not income.
4. **Resources with Zero Value** Property does not cease to be a resource simply because it has no current market value. Even though there is no value to count, the property remains a resource for so long as it meets the definition of a resource in B.2. above. If the property develops a market value at a later time, this is an increase in the value of a resource, not a receipt of income.

M0610.200 UNKNOWN ASSETS

- A. **Policy** Real or personal property the FU/BU is unaware of and had no reason to be aware of is not considered an available resource for the period of time the unit can demonstrate it did not know or had no reason to know about the property. Once the unit becomes aware or has reason to become aware of the existence of the resource, it is considered available to the unit.

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M0630.000 Families and Children (F&C) EXCLUDED RESOURCES

M0630.001 OVERVIEW

- A. Introduction** After determining that an asset meets the definition of a resource, determine that resource's effect on eligibility. Certain resources do not count against the resource limit; i.e., they are excluded.
- B. Procedure** Section M0630.100 below contains the policy and procedures for determining if an individual's resource is excluded from determining eligibility for Medicaid in an F&C covered group.

M0630.100 EXCLUDED RESOURCES

- A. Identifying Excluded Resources** As long as they are identifiable, exclude the resources described in the sections below.
- If any funds derived from an excluded resource are combined with other resources, the individual must provide documentation to verify the excluded amount. Otherwise, the funds must be counted in determining eligibility.
- B. Types of Excluded Resources**
- 1. Resources Owned By SSI Recipient** Resources (real and personal property) owned solely by any individual in the household who is receiving SSI are excluded from the F&C individual's eligibility determination.

When property is owned jointly by an SSI recipient and an F&C applicant/recipient, only the share of the property owned by the F&C individual is considered available.
- 2. Trusts** See M0620.140 to determine if a trust is excluded.
 - 3. Sold or Transferred** When any of the excluded resources are sold or transferred into cash or other liquidable assets, these items are countable resources and will be considered in relation to the applicable resource limit.

EXAMPLE #1: Ms. C sells her excluded vehicle and receives \$500 from the sale. This sum of money is a countable resource.

EXAMPLE #2: Ms. H. sells her excluded home. She receives net proceeds of \$20,000. This money is a countable resource and will be considered in relation to the applicable resource limit.

4. Life Estates

A life estate gives an individual certain property rights for the duration of his or her life, or someone else's life. A life estate in real property is not a countable resource.

C. Procedure

Sections M0630.110 through M0630.160 below contain the policy and procedures for determining whether a resource is partially or totally excluded in the resource eligibility determination.

- M0630.115 Home Property
- M0630.120 Personal Property
- M0630.125 *Savings or Other Investment Account for Purpose of Self-Sufficiency*
- M0630.130 Casualty Property Loss
- M0630.140 Government Program Benefits & Payments
- M0630.150 Education Assistance
- M0630.160 Indian Tribe Funds and Land.

M0630.105 REASONABLE EFFORT TO SELL FOR THE CATEGORICALLY NEEDY COVERED GROUPS**A. Policy**

When ownership of real property alone, or in combination with other countable assets, causes the family/budget unit's resources to exceed the \$1000 resource limit, the applicant/recipient must be given the opportunity to receive Medicaid for the otherwise eligible family/budget unit for a maximum period of nine consecutive months while efforts are being made to dispose of the real property.

B. Determining Nine Month Period

The nine-month period runs for nine consecutive months regardless of whether Medicaid is received during all of that period. For an applicant, the period begins with the first month of entitlement. For a recipient, the nine-month period begins the month in which the recipient receives the property. When it is learned that the recipient owns property which has not been reported, the nine-month period begins in the month the unit became aware or had reason to become aware of the existence of the resource.

C. Procedures**1. Written Notice**

Advise the applicant/recipient, in writing:

- of the amount by which the real property exceeds the resource limit;
- that if he/she is willing to make reasonable effort to sell the property he/she is eligible for Medicaid during the nine-month period, if otherwise eligible.

- that the disposition of the property will be evaluated as an asset transfer.

2. Good Faith Effort

The eligibility worker must:

- Explain to the applicant/recipient that agreeing to sell the property includes making good faith efforts to sell the property within a range of 10% of fair market value.
- Explore with the applicant/recipient ways to satisfy a good faith effort, which includes but is not limited to, listing the property with a real estate company, advertising in various ways, etc. Document discussion.
- Advise that failure to make good faith efforts to sell will result in ineligibility.
- Verify the good faith efforts to dispose of the property during the third and sixth months of the disposal period. Document the case record.

3. Notification of Contract

Advise the applicant/recipient to report to the agency no later than the next working day after a contract to sell the property is made.

4. Failure to Sell

If the property has not been sold in the nine-month period, the individual and family is no longer eligible in an F&C CN covered group. The family remains ineligible until the property has been disposed of or until such time as the property does not preclude eligibility.

D. One-Time Exclusion

This exclusion of property is a one-time per resource, limited exclusion. If the individual reapplies in an F&C or CN covered group and still owns the property, the property cannot be excluded under the reasonable effort to sell provision.

M0630.110 REASONABLE EFFORT TO SELL FOR THE MEDICALLY NEEDY

See policy and procedures in M1130.140

M0630.115 HOME PROPERTY

A. Policy

For all F&C classifications, the home in which the applicant/recipient lives and its contents are excluded.

If income is received from the use of the property or buildings on it, evaluate the income as earned or unearned income according to M07.

B. Definitions

1. Home

The home means the house, lot, and all contiguous property. It also means any buildings, in addition to the house, which are situated on the property.

2. **Contiguous Property** Contiguous property means the land, and improvements which are not separated from the house lot by land owned by others. Streams and public rights of way which run through the property and separate it from the home will not affect the property's contiguity.
3. **Other Shelter as Home Property** If the family/budget unit is using a vehicle, a boat, a camper, or another type of shelter as a home, this shelter is an excluded resource. Ownership of this resource does not affect eligibility for the period of time the family/budget unit lives in it. The month the family/budget unit moves to a house or apartment, the vehicle, boat, camper, or other shelter that the family/budget unit owns becomes an available resource and must be evaluated per M0640.

M0630.120 PERSONAL PROPERTY

A. Motor Vehicle

1. **All Groups Other Than Medically Needy (MN)** *For F&C covered groups other than MN, one motor vehicle with an equity value of \$1,500 or less is excluded.*
2. **MN** For the MN covered groups, one vehicle of any value is excluded.

B. Income-producing Farm or Business Equipment

For all classifications, income producing farming and business equipment is excluded. If farm or business equipment is not producing income, it is countable personal property.

C. Tools and Equipment

For all classifications, the following are excluded:

- tools and equipment belonging to a temporarily disabled member of the family/budget unit during the period of disability;
- tools and equipment belonging to an unemployed parent when such tools and equipment have been and will continue to be used for employment.

D. Life Insurance

1. **All Groups Other Than MN** *For F&C covered groups other than MN, the cash value of any life insurance policy owned by the individual or his/her spouse is counted.*
2. **MN** For MN covered groups, all life insurance policies on a person under age 21 years are excluded.

Any life, retirement, or other related types of insurance policies with face values totaling \$1500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed \$1500, the cash surrender value of the policies is counted as a resource.

E. Burial Plots

1. *All Groups
Other Than
MN*

For F&C covered groups other than MN, one burial plot per member of the family/budget unit is excluded.

2. MN

All burial plots are excluded for MN.

F. EITC Refunds or Advance Payments

For all classifications, Earned Income Tax Credit refunds and advance payments are excluded as resources in the month following the month of receipt. Any portion of the refund or advance payment retained after the month following the month of receipt is a countable resource.

G. Bona Fide Loans

For all classifications, all bona fide loans are excluded, regardless of the intended use. See M0640.800.

M0630.121 BURIAL ARRANGEMENTS

A. *All Groups Other Than MN*

1. **Bona Fide
Funeral
Agreement**

A bona fide funeral agreement covering a family/budget unit member with a maximum equity value of \$1500 per individual is excluded. A bona fide funeral agreement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple "set asides" of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources.

NOTE: Funds in excess of the \$1500 burial limit per individual are counted against the resource limit. See section M0640.500.

2. **Irrevocable
Burial
Contracts**

Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

B. MN

Burial funds are excluded from resources up to a maximum of \$3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the following forms:

- irrevocable burial trusts established on or after August 11, 1993;
- revocable burial trusts;
- revocable burial contracts;

- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).

Use the ABD policy and procedures in M1130.410 and M1130.420 for MN F&C groups.

M0630.125 SAVINGS OR OTHER INVESTMENT ACCOUNT FOR THE PURPOSE OF SELF-SUFFICIENCY

A. Policy

For all covered groups *that have resource requirements*, up to \$5,000 of principal and interest in one savings or other investment account for the purpose of self-sufficiency, is excluded. Investment accounts may include but are not limited to, mutual funds, money market accounts and stock ownership.

Any excess principal and/or interest over the \$5,000 limit is a countable resource.

B. Requirements

1. Must Be Kept Separate

The funds on deposit in such an account cannot be commingled with funds intended for another use.

2. More Than One Account

If the family unit has more than one savings account established for self-sufficiency, the family unit must specify which account is the excluded resource.

3. Withdrawals

Self-sufficiency expenditures may include expenses related to securing and maintaining employment, education, home purchase, vehicle purchase, starting a business or other purposes reasonably determined to promote self-sufficiency. If any amount is withdrawn from the account for any purpose other than self-sufficiency, any portion of the amount determined to be misused will be treated as a countable resource in the month following the month withdrawn, if it is retained.

C. Notification

The eligibility worker must explain the policy in this section to the applicant/recipient who has one of these accounts.

D. Documentation

When a savings or investment account established for the purpose of self-sufficiency is first reported or discovered, the agency must verify the amount in the account and obtain a written statement from the applicant/recipient which includes the purpose of the account. The balance must be verified at application and redetermination.

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M0640.000 TYPES OF COUNTABLE RESOURCES

M0640.001 OVERVIEW

A. Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the asset:

- is a resource, based on instructions in the M0610 subchapter; and
- is not an excluded resource, based on instructions in the M0630 subchapter.

NOTE: A trust may or may not be a countable resource. See M0620.140 to determine if a trust established by a will is a countable resource. For all other trusts, see M1120.201.

NOTE: If the individual is a married institutionalized individual, go to *subchapter M1480*.

REAL PROPERTY

M0640.100 NON-HOME REAL PROPERTY

A. Definition

Non-home real property consists of land and buildings or immovable objects that are attached permanently to the land and that do not meet the definition of a home (house, lot and all contiguous property).

B. Development and Documentation of Fair Market Value

Ascertain fair market value from the Commissioner of Revenue or Assessor's Office.

C. Ownership/Value

1. Sole Owner

If the applicant/recipient is the sole owner, the property is a resource.

If the applicant/recipient is the sole owner with a living spouse, the property is a resource to the applicant/recipient regardless of the spouse's willingness to join in a deed to sell the property.

2. Tenants by Entirety

If the property is held by the applicant/recipient and spouse as tenants by the entirety with survivorship at common law:

- a. When the applicant/recipient and spouse are living together, the property is a resource regardless of the spouse's consent to sell.

When the spouses live apart, if the separated spouse gives consent to dispose of property, one-half of the total value of the property is

considered a resource to the applicant/recipient. If the separated spouse does NOT give consent to dispose of property, **none** of the property is counted as a resource to the applicant/recipient.

- b. If a decree of divorce has been entered, one-half of the total value of the property is considered a resource.
- c. If the spouse is deceased, *the* total value of the property is a resource.
- d. If the non-applicant spouse cannot be located by the agency or if that spouse refuses to cooperate with the agency, he/she is considered unwilling to give his/her consent to sell the property or to join in a deed and the property is not a resource. Document the case record regarding the separated spouse's refusal to cooperate or the agency's inability to locate the applicant's spouse.

3. Tenants in Common

If the applicant/recipient jointly owns property with other than a spouse as tenants in common or joint tenants, the applicant/recipient's prorata share is considered a resource. If the joint owner refuses to join in a deed to sell the property, the estimated cost of a partition suit is deducted to determine the value of the applicant/recipient's share of the property.

- a. If documentation does not clearly establish the applicant/recipient's interest in jointly owned property, the eligibility worker must contact the Medicaid Regional Specialist to obtain an interpretation from the Assistant Attorney General.
- b. Deduct the estimated cost of partitioning and attorney fees in establishing equity value when the joint owner refuses to join in a deed to sell:
 - Estimated costs associated with a partition suit must be based on prevailing community charges as determined by a local person having knowledge of the cost of such an action.
 - Shared partition costs (commissioner's fees, survey costs, etc.) are deducted from the whole property's value.
 - The individual's attorney's fees is deducted from the individual's prorata share of the property value that remains after deducting shared partition costs (and liens, if any).
 - After calculation, add the remainder to other countable resources and compare the total to the resource limit for the FU/BU classification.

M0640.110 OTHER PROPERTY RIGHTS

A. Life Estates A life estate gives an individual certain property rights for the duration of his or her life, or someone else's life. A life estate in real property is not a countable resource.

B. Remainder Interest When property is owned by one party and a second party has a life estate or "life rights" to the property, then the first party has a remainder interest in the property. A remainder interest is a countable resource.

To determine the fair market value of a remainder interest in property, multiply the tax assessed value of the property by the fraction corresponding to the age of the individual who has life rights. M0640, Appendix 1 contains the table used to perform this calculation.

M0640.200 CASH AND LIQUID ASSETS

A. Policy Cash held by the individual is a resource. Money in a financial institution is a liquid asset and is a resource. Absent evidence to the contrary, assume that the person designated as the owner on the account owns all the funds in the account and has the right to withdraw funds from the account.

Interest received is treated as income in the month received and as a resource thereafter.

- B. Development and Documentation**
1. Document, in addition to the balances themselves:
 - the name and address of the financial institution;
 - the account number(s); and
 - the exact account designation.
 2. Cash and liquid assets can be verified by documentation in the individual's possession such as: savings account book, bank statement, trust agreements, or affidavits.
 3. Other acceptable verification includes bank clearances, credit union records, savings and loan records, and joint bank account statements.
 4. When it is necessary to request account information from a financial institution, have the individual sign an authorization for the release of the information.

M0640.210 JOINT BANK ACCOUNTS

A. Policy If it is established that an applicant/recipient, owns a joint bank account with another party and that all funds in the joint account belong to the other party, and the account was established for the convenience of the other party, it is not considered a resource to the applicant/recipient.

If it cannot be established that all the funds in the account belong to the other party, the applicant/recipient's pro rata share will be considered the

resource.

B. Development and Documentation

Verify ownership of the account by a statement from both parties. If a statement of ownership cannot be obtained from both parties, assume the applicant/recipient owns a pro rata share of the account. For example, if the account is owned by the applicant/recipient and one other individual, the applicant/recipient's pro rata share is one-half.

M0640.300 MOTOR VEHICLES

A. Policy

1. ***All Groups Other Than MN*** One motor vehicle owned by the FU/BU with an equity value up to \$1500 is excluded. Any equity value above \$1500, is a countable resource.
2. **MN** One vehicle of any value is an excluded resource.
3. **Used as a Home** For all classifications, if the FU/BU is using a vehicle, a boat, or a camper as a home, the vehicle is excluded for the period of time the FU/BU lives in it. The month that the FU/BU moves to a house or an apartment the vehicle, boat, camper, or other shelter that the FU/BU owns becomes an available resource and must be evaluated.

B. Value of Vehicle

1. **Listed in NADA** The average trade-in value listed in the current NADA Official Used Car Guide or the average trade-in value listed in the NADA Official Older Used Car Guide is considered the fair market value from which encumbrances must be deducted in order to establish equity value. Do not adjust the average trade-in value amount specified in the NADA guides for optional features, special equipment for the handicapped, mileage, condition, operability, etc.
2. **Not Listed in NADA** If a motor vehicle is not listed in the current NADA Guide, or the Older Used Car Guide, the applicant/recipient may provide a statement of assessment for tax purposes which contains the value of the vehicle in order to establish the equity value.
3. **Licensed Dealer's Statement** If a tax assessment statement is not available, the applicant/recipient can provide a licensed dealer's statement in order to establish the value. It is the responsibility of the applicant/recipient to obtain this licensed dealer's statement, but if assistance is requested, the EW must contact a licensed dealer to ascertain the fair market value.
4. **Re-verification of Equity Value** Re-verify the motor vehicle's equity value only at redetermination unless the recipient reports a change in equity value before redetermination.

5. ***Disputed Value***

If the applicant/recipient disagrees with the fair market value established by the agency, the individual must be given an opportunity to dispute the finding and provide the agency with a written statement of the value from a disinterested knowledgeable source, such as a used car dealer.

If eligibility is established using the revised vehicle value, the value of the vehicle is not re-verified at subsequent redeterminations.

C. Ownership of Two or More Vehicles1. ***All Groups Other Than MN***

If two or more motor vehicles are owned by the family/budget unit, the motor vehicle with the highest equity value will be excluded up to \$1,500.

The equity value in all other vehicles plus the equity value above \$1500 in the excluded vehicle is combined and is counted as a resource.

2. ***MN***

If more than one vehicle is owned, the individual's vehicle with the highest equity value is excluded. The equity value in all other vehicles must be counted. The value used for countable vehicles is the average trade-in value listed in NADA Guide. In the event the vehicle is not listed, the value assessed by the locality for tax purposes may be used.

D. Motor Vehicles Jointly Owned

If a motor vehicle is owned jointly by a member of the family/budget unit with any individual not in the family/budget unit, the agency must establish whether or not the non-member is willing to sell the vehicle(s).

If the non-member is willing to sell, the family/budget unit member's prorata share of the equity is considered an available resource.

If it is established that the non-member is not willing to sell, then the vehicle(s) is not counted as a resource. The non-member's refusal to cooperate with the agency or the agency's inability to locate the non-member is considered his/her unwillingness to sell the property.

M0640.400 LIFE INSURANCE**A. Policy**1. ***All Groups Other Than MN***

A life insurance policy is a resource if it generates a cash surrender value (CSV). Its value as a resource is the amount of the CSV.

All life insurance policies on a person under age 21 years are excluded.

2. ***MN***

Any life, retirement, or other related types of insurance policies with face values totaling \$1,500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed \$1,500, the cash surrender value of the policies is counted as a resource.

- B. Development and Documentation** Verify the availability and the cash value of the policy by contacting the insurance companies or examining the policies of all family/budget unit members.

M0640.500 BURIAL ARRANGEMENTS FOR COVERED GROUPS *OTHER THAN MN*

- A. Policy** A bona fide funeral agreement covering a family/budget unit member, with a maximum equity value of \$1,500 per individual is excluded. A bona fide funeral arrangement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple “set asides” of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources. See M0630.121.
- B. Excess Funds** Funds in excess of the \$1,500 per individual limit are counted against the resource limit.
- C. Irrevocable Contracts** Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

M0640.510 BURIAL ARRANGEMENTS FOR THE MEDICALLY NEEDY

- A. Policy** Burial funds are excluded from resources up to a maximum of \$3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the following forms:
- irrevocable burial trusts established on or after August 11, 1993;
 - revocable burial trusts;
 - revocable burial contracts;
 - other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
 - cash;
 - financial accounts (e.g., savings or checking accounts);
 - other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).
- B. Reduction of Burial Exclusion** The maximum exclusion amount is reduced by:
1. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and
 2. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting

M0710.000 GENERAL-- F & C INCOME RULES**M0710.001 OVERVIEW****A. Introduction**

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. This section addresses how to determine an individual's income eligibility.

B. Use of Family Units/Budget Units

Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU) rules permit, form BUs.

Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.

See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.

C. Individual Income Eligibility

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

D. Policy Principles**1. Income**

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

2. Verification

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information *cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker*, a third party statement, a collateral contact, *or as a last resort, the applicant's/recipient's written statement can be used as verification* and to determine the amount of

income to be counted. Failure to verify income results in inability to determine Medicaid eligibility and Medicaid coverage must be denied or cancelled.

- 3. Converted Income**

For the ongoing evaluation period, all income received more frequently than monthly must be converted to a monthly amount.

 - Weekly income is multiplied by 4.3
 - Bi-weekly income is multiplied by 2.15
 - Semi-monthly income is multiplied by 2.
- 4. Actual Income**

When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.
- 5. MI, CN, CNNMP Monthly Income Determination Period**

An income eligibility determination is made for each calendar month for which eligibility is being evaluated in the Medically Indigent (MI), Categorically Needy (CN), and Categorically Needy Non-Money Payment (CNNMP) classifications.
- 6. MN - Ongoing 6 Month Income Determination Period**

Medically Needy (MN) income eligibility for the ongoing period is based on income that is anticipated to be received within the six month period beginning with the month of application.
- 7. MN - Retro 3 Month Income Determination Period**

MN income eligibility for the retroactive period is based on income that was actually received in the three month period immediately prior to the month of application.
- 8. Countable Income**

Assets that meet the definition of income minus the exclusions allowed by policy are countable income. Only countable income is used to determine income eligibility. See M0720 Earned Income, M0730 Unearned Income.
- 9. Whose Income is Counted**

The total countable income of all FU members is used in determining the income eligibility of each FU member.

The total countable income of all BU members is used in determining the income eligibility of each BU member.
- 10. Income Eligibility**

If the total amount of the FU/BU's countable income is equal to or less than the income limit for the evaluation period, income eligibility exists.
- 11. Excess Income**

When an FU has countable income totaling more than the allowable CN, CNNMP, or MI income limit for the evaluation period, eligibility at the FU level does not exist. If ineligible at the FU level and policy permits breaking the FU into BUs, a BU evaluation must be completed.

When a BU has countable income totaling more than the allowable CN, CNNMP, or MI income limit for the evaluation period,

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 *FU*'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 *FU* is equal to or less than 100% of the FPL, then the unearned income is screened as the F&C 90% income limit for the locality. If the *FU*'s unearned countable income is equal to or less than the F&C 90% income limit, income eligibility for VIEW participants in the LIFC covered group is established.

If the *FU*'s earned or unearned income exceeds the limits, the *FU* is not eligible as VIEW participants in the LIFC covered group. *BU policy does not apply to the VIEW participant income eligibility determination.* Determine if any family members are eligible as LIFC (non-VIEW) or in any other covered group.

**1. Step 1-
Earned
Income**

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

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

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

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

**2. Step 2-
Unearned
Income**

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

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

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

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

M0720.000 F & C EARNED INCOME**M0720.001 OVERVIEW**

A. Introduction This subchapter provides policy and procedures for identifying and counting earned income.

B. Policy

1. What Earned income may be received in cash and consists of:

**Constitutes
Earned
Income**

- wages
- profit from self-employment

The source and amount of all earned income other than Workforce Investment Act and student income must be verified.

**2. Earned Income
Exclusions**

Earned income exclusions are subtracted from the gross monthly income in determining eligibility.

C. References

- Income From Self-Employment, M0720.200
- Income From Real Property, M0720.250
- Income From Room and Board, M0720.260
- Income From Day Care, M0720.270
- Income From Small Businesses/Cash Crops, M0720.280
- Contract Income, M0720.400
- Earned Income Exclusions, M0720.500

M0720.100 WAGES -- GENERAL

A. Definition Wages are what an individual receives (before deductions; not "take home" pay) for working as someone else's employee.

NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages.

B. Policy

**1. Kinds of
Wages**

Wages may take the form of:

- contract earnings
- commissions

- pay for jury duty
- severance pay
- tips
- vacation pay
- sick pay from employer or employer-obtained insurance

2. When to Count

Wages are calculated on a monthly basis and counted at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

Absent evidence to the contrary, if FICA taxes have been deducted from an item, assume it meets the definition of wages. Failure to deduct FICA taxes does not mean the income is not wages.

EXAMPLE #1:

Mrs. Green is employed by Mr. Brown who owns a small business. Mr. Brown does not deduct FICA taxes from Mrs. Green's income. Mrs. Green's income from Mr. Brown is wages.

C. Verification

Verify wages, salaries, and commissions by pay stubs, pay envelopes, a written statement from the employer, or by the eligibility worker's verbal contact with the employer.

When attempts to verify income are unsuccessful because the person or organization who is to provide the information *cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker*, a third party statement, a collateral contact, *or as a last resort, the applicant's/recipient's written statement can be used as verification* and to determine the amount of income *to be counted*.

Verify tips by a weekly record of the tips prepared by the employed individual.

M0720.105 INCOME FROM A CORPORATION

If a person has incorporated a self-employment enterprise either alone or with other persons and draws a salary from the business, the wages drawn are regular earned income, not self-employment income.

M0720.110 HOW TO COUNT INCOME IN THE RETROACTIVE PERIOD

When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

M0720.155 HOW TO ESTIMATE EARNED INCOME

A. General

Ongoing income eligibility is determined based on the income that is anticipated (expected) to be received within the ongoing evaluation

S0830.115 GARNISHMENT OR OTHER WITHHOLDING

A. Policy

Unearned income includes amounts withheld from unearned income because of garnishment or to make certain other payments.

Unearned income includes amounts withheld from unearned income whether the withholding is:

- purely voluntary;
- to repay a debt; or
- to meet a legal obligation.

NOTE: This policy does not apply to amounts withheld to pay the expenses of obtaining the income since such amounts are not income. See S0830.100.

B. Kinds of Withholding

Some items for which amounts may be withheld but considered received are:

- Federal, State, or local income taxes;
- health or life insurance premiums;
- SMI premiums;
- union dues;
- penalty deductions for failure to report changes;
- loan payments;
- garnishments;
- child support payments (court ordered or voluntary (exception-deemors));
- service fees charged on interest-bearing checking accounts;
- inheritance taxes;
- guardianship fees if presence of a guardian is not a requirement for receiving the income (see S0830.100).

C. Procedure

Use documents in the individual's possession or contact the source of the payment to verify the amount withheld. Add the amount withheld to the amount received and consider the total as unearned income from that source.

D. Reference

Overpayment involved, S0830.110

BROAD CATEGORIES OF UNEARNED INCOME

S0830.160 ANNUITIES, PENSIONS, RETIREMENT, OR DISABILITY PAYMENTS

A. Definitions

1. **Annuity** An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer
2. **Pensions and Retirement Benefits** Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.
3. **Disability Benefits** Disability benefits are payments made because of injury or other disability.

B. Policy

1. **General Rule** Annuities, pensions, retirement benefits, and disability benefits are unearned income.
2. **Exceptions** **Certain accident disability benefit paid within the first 6 months** after the month an employee last worked are earned income. For a further explanation of sickness and accident disability payments, see S0820.005.

A Qualified Domestic Relations Order (QDRO) is a court order, usually the result of a divorce or separation proceeding that changes the ownership of the pension asset and the income stream from one individual to another. To be valid, a QDRO must: 1) be a decree issued by a state court; 2) provide the names and addresses of participants and the amount or percentage of the benefit; and 3) be approved by the pension plan administration.

When a QDRO splits the income between a Medicaid applicant/recipient and the spouse, count only the income that is ordered to go to the Medicaid applicant/recipient as his income. If the plan administrator has not approved the QDRO or disapproved it, the income should be calculated without regard to the court order.

C. List of Payments

The following provides a list of instructions which address particular payments:

Black Lung Benefits.....	S0830.215
Foreign Payments	S0830.105
German Reparations Payments	S0830.710
Military Pensions	S0830.240
Office of Personnel Management (Civil Service and Federal Employment Retirement System) Payments.....	S0830.220
Railroad Retirement Payments.....	S0830.225
Title II Payments	S0830.210
VA Payments	S0830.300
Worker's Compensation Payments.....	S0830.235

PERSONAL PROPERTY

M1130.200 AUTOMOBILES

A. Policy Principles

1. **Automobile Defined** For ABD Medicaid purposes, "automobile" means any vehicle used for **transportation**. It thus can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and even animals.
2. **Current Market Value Defined** The CMV of an automobile is the average trade-in value listed in the NADA Guide.
3. **Exclusion Regardless of Value** Ownership of one motor vehicle does not affect eligibility. One automobile, regardless of value, is excluded for the individual or a member of the individual's household.
4. **Other Automobiles** Any automobile an individual owns in addition to the one excluded will be evaluated as a countable resource.

B. Operating Policy-- More than One Automobile Owned

1. **General Rule** If more than one automobile is owned, *one automobile will be excluded and the other will be a countable resource. The exclusion will apply to the automobile with the highest equity value.*
2. **Determining Equity Value** *Use the following method to determine equity value:*
 - *Determine the average trade-in value for each automobile from the NADA Guide. In the event the automobile is not listed, the value assessed by the locality for tax purposes may be used.*
 - *Determine the equity value in each automobile by subtracting the debt from NADA value.*
 - *Exempt the automobile with the highest equity value.*
3. **References** See M1110.400 for what values apply to resources.
See Appendix 1 for QDWI development.

M1130.300 LIFE INSURANCE

A. Definitions

1. **Life Insurance Policy** A life insurance policy is a contract. Its purchaser (the owner) pays premiums to the company that provides the insurance (the insurer). In return, the insurer

agrees to pay a specified sum to a designated beneficiary upon the death of the insured (the person on whom, or on whose life, the policy exists).

2. Face Value

Face value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such, or as the "amount of insurance", "the amount of the policy," "the sum insured," etc. A policy's FV does not include:

- the FV of any dividend addition, which is added after the policy is issued (see 5. below);
- additional sums payable in the event of accidental death or because of other special provisions; or
- the amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other(s).

3. Cash Surrender Value

A policy's cash surrender value (CSV) is a form of equity value that it *accrues* over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV.

4. Dividends

Periodically (annually, as a rule), the insurer may pay a share of any surplus company earnings to the policy owner as a dividend.

Depending on the life insurance company and type of policy involved, dividends can be applied to premiums due or paid by check or by an addition or accumulation to an existing policy.

5. Dividend Additions and Accumulations

a. Additions

Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV.

The table of CSV's that comes with a policy does not reflect the added CSV of any dividend additions.

b. Accumulations

Dividend accumulations are dividends that the policy owner has constructively received but left in the custody of the insurer to accumulate as interest, like money in a bank account. They are not a value of the policy per se; the owner can obtain them at any time without affecting the policy's FV or CSV.

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision (e.g., as set aside for burial), they are a countable resource.

- is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

M1410.020 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

- A. Introduction** To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in chapter M02 apply to all Medicaid applicants and recipients, including those individuals in long-term care. The non-financial requirements and the location of the manual policy for each requirement are:
- B. Citizenship/
Alienage** The citizenship and alien status policy is found in M0220.
- C. Virginia Residency** The Virginia state resident policy for patients in medical institutions is found in subchapter M1430.101; the state resident policy for CBC patients is found in M0230.
- D. Social Security
Number** The social security number policy is found in M0240.
- E. Assignment of
Rights** The assignment of rights and support cooperation policy is found in M0250.
- F. Application for
Other Benefits** The application for other benefits policy is found in M0270.
- G. Institutional
Status** The institutional status policy for facility patients is in subchapter M1430.100. The institutional status policy for CBC waiver services patients is found in subchapter M1440.010.
- H. Covered Group
(Category)** The Medicaid covered groups eligible for long-term care services are listed in subchapter M1460. The category requirements for the covered groups are found in chapter M03.

M1410.030 FACILITY CARE

- A. Introduction** Medicaid covers care provided in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. Some institutions have both medical and residential sections. An individual in the medical section of the institution is a patient in a medical facility; however, an individual in the residential portion of the institution is a resident of a residential facility NOT a patient in a medical facility.

This section contains descriptions of the types of **facilities** (medical institutions) in which Medicaid provides payment for services received by eligible patients. See subchapter M1430 for specific policy and procedures which apply to patients in facilities.

B. Ineligible Individuals

The following individuals are not eligible for Medicaid:

- an inmate in a public institution; see section M1430.102 for the definition of an inmate in a public institution.
- individuals under age 65 who are patients in an institution for mental diseases (IMD), unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

The following are types of medical institutions in which Medicaid will cover part of the cost of care for eligible individuals:

1. Chronic Disease Hospitals

Specially certified hospitals, also called "**long-stay hospitals**". There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C., and
- Lake Taylor Hospital in Norfolk, Virginia.

2. Hospitals and/or Training Centers for the Mentally Retarded

Facilities (medical institutions) that specialize in the care of mentally retarded individuals. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are certified by the Department of Health to provide care in a group home setting. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF/MR because ICF/MR services are not covered for the medically needy.

3. Institutions for Mental Diseases (IMDs)

A hospital, nursing facility or other medical institution that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is not an IMD.

NOTE: Medically needy (MN) patients age 65 or older are not eligible for Medicaid payment of LTC in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Intermediate Care Facility (ICF)

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services in addition to room and board which can be made available only in an institutional setting.

5. Nursing Facility

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

- 6. Rehabilitation Hospitals** A hospital certified as a rehabilitation hospital, or a unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1410.040 COMMUNITY-BASED CARE WAIVER SERVICES

- A. Introduction** Medicaid covers long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.
- This section provides general information about the Community-based Care (CBC) Waiver Services covered by Medicaid. The detailed descriptions of the waivers and the policy and procedures specific to patients in CBC are contained in subchapter M1440.
- B. Community-Based Care Waivered Services (CBC)** Community-Based Care Waiver Services or Home and Community-based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by the Department of Medical Assistance Services (DMAS) that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.
- C. Virginia's Waivers** Virginia has approved Section 1915(c) home and community-based *care* waivers. *These waivers contain services* that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in subchapter M1440. An individual cannot receive services under two or more waivers simultaneously; the individual can receive services under only one waiver at a time.
- 1. Elderly and Disabled Waiver** This waiver is also called the “Aged, Blind, or Disabled (ABD) Waiver” or the “E & D Waiver.” Services available through this waiver *include*:
- adult day health care
 - personal care
 - respite care
- 2. Mental Retardation Waiver** The Mental Retardation (*MR*) Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR, and to individuals with related conditions currently residing in nursing facilities who require specialized services.

Services available through the MR waiver include:

- day support
- supported employment
- residential support
- therapeutic consultation
- personal assistance
- respite care
- nursing services
- environmental modification
- assistive technology

3. AIDS Waiver

Services to individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency syndrome) or who are HIV positive and are symptomatic; the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

Services available to recipients of the AIDS Waiver include:

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care

4. Technology-Assisted Individuals Waiver

"Technology-Assisted" individual is one who is chronically ill or severely impaired, who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The services provided through the waiver are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility.

The services provided under this waiver include:

- private duty nursing
- respite care
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

5. Consumer-Directed Personal Attendant Services Waiver

The "Consumer-Directed Personal Attendant Services (CDPAS) Waiver" provides consumer-directed personal attendant services to aged individuals and disabled individuals who would otherwise require institutionalization in a nursing facility. *If an individual is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient. Supervision of the personal attendant will be furnished directly by the recipient and/or the person directing the care for the recipient.*

M1430.100 BASIC ELIGIBILITY REQUIREMENTS

- A. Overview** To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in *chapter M02* apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.
- B. Citizenship/
Alienage** The citizenship and alien status policy is found in *subchapter M220*.
- C. Virginia Residency** The Virginia state resident policy specific to facility patient is found in *subchapter M0230* and section M1430.101 below.
- D. Social Security
Number** The social security number policy is found in *subchapter M0240*.
- E. Assignment of
Rights** The assignment of rights is found in *subchapter M0250*.
- F. Application for
Other Benefits** The application for other benefits policy is found in *subchapter M0270*.
- G. Institutional
Status** The institutional status requirements specific to long-term care in a facility are in *subchapter M0280* and section M1430.102 below.
- H. Covered Group
(Category)** The Medicaid covered groups eligible for LTC services are listed in M1460. The requirements for the covered groups are found in *chapter M03*.
- I. Financial
Eligibility** The asset transfer policy in M1450 applies to all facility patients.
- Financial eligibility is determined as a one-person assistance unit separated from his/her legally responsible relative(s).
- For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.
- For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

M1430.101 VIRGINIA RESIDENCE

- A. Policy** An individual must be a resident of Virginia to be eligible for Virginia Medicaid while he/she is a patient in a medical facility. There is no durational requirement for residency.
- B. Individual Age 21 or Older** An institutionalized individual age 21 years or older is a resident of Virginia if:
- the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period; or
 - the individual became incapable of declaring his intention to reside in Virginia at or after becoming age 21 years, he/she is residing in Virginia and was not placed here by another state government agency.
- 1. Determining Incapacity to Declare Intent** An individual is incapable of declaring his/her intent to reside in Virginia if:
- he has an I.Q. of 49 or less or has a mental age of less than 7 years;
 - he has been judged legally incompetent; or
 - medical documentation by a physician, psychologist, or other medical professional licensed by Virginia in the field of mental retardation supports a finding that the individual is incapable of declaring intent to reside in a specific state.
- 2. Became Incapable Before Age 21** An institutionalized individual age 21 years or older who became incapable of stating intent before age 21 is a resident of Virginia if:
- the individual's legal guardian or parent, if the parents reside in separate states, who applies for Medicaid for the individual resides in Virginia;
 - the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
 - the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
 - the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.

M1440.106 CONSUMER DIRECTED PERSONAL ATTENDANT SERVICES WAIVER

A. General Description

The “Consumer Directed Personal Attendant Services (CDPAS) Waiver” provides consumer-directed personal attendant services to aged and disabled individuals who would otherwise require institutionalization in a nursing facility. The object of the waiver is to provide long-term maintenance or in-home supportive services specific to the needs of persons with physical disabilities. Personal attendant services are necessary to prevent nursing facility placement and to provide optimum conditions for participating recipients to live as integrated members of society.

Individuals who are eligible for this waiver are:

- aged individuals (age 65 years or older), and
- disabled individuals

who would otherwise require institutionalization in a nursing facility.

Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.).

C. Services Available

The only services available through this waiver are personal attendant care services. Personal attendant services include assistance with the following which are essential to the health and welfare of the individual:

- activities of daily living (eating, bathing, dressing, etc.),
- meal preparation,
- shopping (getting to and from the store, obtaining groceries, etc.),
- housekeeping (bedmaking, washing dishes, dusting, etc.),
- laundry,
- money management (paying bills, writing checks, etc.).

Supervision of the personal attendant will be furnished directly by the recipient and/or the person directing the care for the recipient.

Personal attendants may be members of the recipient's family, other than the spouse of the recipient, or a parent or stepparent of a recipient under age 18 years of age or anyone who has legal guardianship or is a committee/conservator for the recipient.

D. Assessment and Service Authorization

The initial assessment and development of the plan of care is conducted by the Nursing Home Pre-admission Screening (NHPAS) Teams in acute care facilities and in the community that perform long-term care screenings for Medicaid nursing facility and waiver services. The screening team's assessment is sent to DMAS or its contractor for final authorization. The individual's plan of care is subject to review every 30 days for the first 3 months of service. The individual's level of care will be reviewed every 6 months by the provider submitting a re-evaluation to DMAS or its contractor.

M1440.107 INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER (DD WAIVER)

A. General Description

The Individual and Family Developmental Disabilities Support Waiver (DD waiver) provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of mental retardation. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

This waiver serves persons who:

- have a diagnosis of developmental disability attributable to cerebral palsy, epilepsy or autism, or
- any condition other than mental illness, found to be closely related to mental retardation.

The developmental disability must have been manifested prior to the individual reaching age 22 and must be likely to continue indefinitely.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). Medically needy individuals are not eligible for this

his ongoing Medicaid coverage began. His ongoing coverage began on March 1; the second month following March is May, so the Buy-in will begin in May. His Medicare premium is not deducted from his patient pay for May and subsequent months.

**C. Non-covered
Medical/Dental
Services**

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be *approved* by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See C.3. for examples of services that are included in the facility per diem rate.

**1. Zero Patient
Pay
Procedures**

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient (and the patient's representative, if appropriate) using the "Notice of Obligation for LTC Costs". This form provides notice of the right to appeal the agency's decision.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

**2. Allowable
Non-covered
Expenses**

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds \$500.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay.

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed \$500. **If the service is not identified in the list below and/or the cost of the service exceeds \$500, send the request and the documentation to DMAS for approval. DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.**

- routine dental care, necessary dentures and denture repair for recipients 21 years of age and older. **Pre-approval for dental services that exceed \$500 must be obtained from DMAS prior to receipt of the service;**
- routine eye exams, eyeglasses and eyeglass repair;
- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid recipient during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds \$500.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

- a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:
 - diabetic and blood/urine testing strips,
 - bandages and wound dressings,
 - standard wheelchairs,
 - air or egg-crate mattresses,
 - IV treatment,
 - splints,
 - certain prescription drugs (placebos).
- b. TED stockings (billed separately as durable medical supplies),
- c. acupuncture treatment,
- d. massage therapy,
- e. personal care items, such as special soaps and shampoos,
- f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

The local agency can make the adjustment for services identified in subsection C. 2. b. through d.1), above providing the cost of the service does not exceed \$500. If the cost of the service is not identified in subsection C. 2. b. through d. 1), or exceeds \$500, send the documentation to DMAS to obtain approval *and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).*

b. Requests For Adjustments From LTC Providers

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or DMHMRSAS facility, the request must be accompanied by:

- 1) the recipient's correct Medicaid ID number;
- 2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);
- 3) actual cost information;
- 4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and
- 5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds \$500, send the request and the documentation to DMAS to obtain approval for the adjustment *and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate)*. DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

5. Procedures

a. DMAS Approval Required

Requests for adjustments to patient pay for services not included in subsection C.2. b. through d.1) above, or for any service which exceeds \$500, must be submitted by the provider to the DSS worker. The DSS worker sends the request and documentation, along with the most recent copy of the DMAS-122 to:

DMAS-122 Program Support Technician Sr.
Payment Processing, Program Services Section
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

NOTE: Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to c. below for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

- 1) If approved, adjust the patient pay. Prepare a new DMAS-122. See the notice requirements in c. below.
- 2) If the adjustment request is denied, DMAS prepares the notification.

D. Expected Contributions From Legally Responsible Relative An expected contribution from a legally responsible relative is not counted unless it is actually contributed to the institutionalized *child* or spouse. *If a separated spouse has income over the spousal maximum maintenance standard (see M1480.410) or a higher amount set by hearing officer or judge, an expected contribution of income is determined using the scale in Appendix 6 to this subchapter. However, the contribution is not counted as income available to the institutionalized spouse for patient pay or the eligibility determination unless it is actually made available to the institutionalized spouse from the separated spouse.*

The separated spouse has no expected contribution if his income is less than or equal to the spousal maximum maintenance standard in subchapter M1480 (or a higher amount determined by a DMAS hearing officer or court judge as necessary for the separated spouse's maintenance needs) or if the separated spouse receives an allowance from the institutionalized spouse's income.

M1480.320 RETROACTIVE MN INCOME DETERMINATION

A. Policy The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.

1. Institutionalized For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.

2. Individual Not Institutionalized For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.

3. Retroactive Entitlement If the applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CNNMP in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**

C. Entitlement Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will

begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met his spenddown, he is enrolled beginning the first day of the month in which his retroactive spenddown was met. For additional information refer to section M1510.101.

D. Retroactive Example

EXAMPLE #15: A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. His countable resources are less than \$2,000 in April, May and June. The income he received in April and May is counted monthly because he was institutionalized in each month.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the CNNMP 300% SSI covered group for May.

M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if he meets a medically needy (MN) covered group and has countable resources that are less than or equal to the MN resource limit. His income is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

B. Recalculate Income

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

1. ABD MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

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**

\$1,515.00	7-1-03	
\$1,492.50	7-1-02	
- C. Monthly Maintenance Needs Allowance Maximum**

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

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

\$206	1 - 3 household members	10-1-03
\$253	4 or more household members	10-1-03
\$194	1 - 3 household members	10-1-02
\$240	4 or more household members	10-1-02

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).

M1510.000 ENTITLEMENT POLICY & PROCEDURES**M1510.100 MEDICAID ENTITLEMENT**

- A. Policy** If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month. However, if the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.
- B. SSI Entitlement Date Effect on Medicaid** SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.
- C. Procedures** The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:
- M1510.101 Retroactive Eligibility & Entitlement
 - M1510.102 Ongoing Entitlement
 - M1510.103 Disability Denials
 - M1510.102 Foster Care Children.

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT**A. Definitions**

- 1. Retroactive Period** The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be CN, CNNMP or MI in one or two months and MN in the third month, or any other combination of classifications.
- 2. Retroactive Budget Period** The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

- B. Policy** An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

C. Budget Periods By Classification

1. CN, CNNMP, MI

The retroactive budget period for categorically needy (CN), categorically needy non-money payment (CNNMP) and medically indigent (MI) covered groups (categories) is one month.

CN, CNNMP or MI eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. Medically Needy (MN)

In the retroactive period, the **MN budget period is always all three months** in the retroactive period. Unlike the CN, CNNMP or MI, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN, CNNMP or MI.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN, CNNMP or MI retroactive coverage for those months.

EXAMPLE #1: *Ms. A* applied for Medicaid for *herself* and *her* children on July 8. *She* reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. *She* currently receives Unemployment Compensation; *she lost her job* in May. *She* provided all required verification for May and June, but did not provide *income verification* for April. Their application was approved for *MI Medicaid* coverage beginning May 1; April coverage was denied because of failure to verify *income* for April.

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

1. MI Pregnant Woman

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

Following the end of the postpartum period, the MI pregnant woman continues to be eligible for Medicaid in the Family Planning Services (see M0320.302) covered group for 10 months (12 months following the end of the pregnancy) regardless of any change in income.

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. *The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is within 90 days of the 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 12-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

A redetermination of eligibility of an MI pregnant woman who applied on or before the end of her pregnancy is not required until 12 months following the end of her pregnancy. 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. Reinstate the Family Planning Services limited coverage in the MMIS the first day of the month following the end of the 60-day postpartum period. Do not use change transactions to move an individual between full and limited coverage.

The recipient may request a redetermination 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.

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
(FAMIS Plus)**

The Medicaid eligibility of children in the MI Child Under Age 19 (*FAMIS Plus*) 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 the 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 is not eligible because of resources, send an advance notice and cancel the child's Medicaid coverage in the MMIS. If the child is not eligible because of income, send an advance notice and cancel the child's Medicaid coverage because of excess income, and place the child on a medically needy spenddown.

**5. Family
Planning
Services (FPS)**

The Medicaid eligibility of women in the FPS covered group must be redetermined *12 months following the end of the pregnancy. If the woman remains eligible, she is entitled to an additional 12 months of FPS coverage.* The *Application for MI Pregnant Women*, the Eligibility Review Part A and the Eligibility Review Part B, the ADAPT Statement of Facts, or other appropriate forms can be used for the redetermination.

- 6. ABD 80% FPL** The Medicaid eligibility of individuals in the ABD 80% FPL covered group must be redetermined at least once every twelve months. 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 for the redetermination.
- 7. QMB, SLMB and QDWI** The Medicaid eligibility of individuals in the QMB, SLMB, and QDWI covered groups must be redetermined at least once every twelve months. The twelve-month review period begins with the month of application for Medicaid. Use forms the Eligibility Review Part A and the Eligibility Review Part B forms for the redetermination.
- 8. Qualified Individuals** The Medicaid eligibility of individuals in the Qualified Individuals covered group cancels on December 31 of each calendar year. An Application for Benefits must be completed each calendar year.
- E. Recipient Becomes Institutionalized** When an enrolled recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, redetermine the recipient's eligibility as an individual institutionalized in a medical facility, or an individual receiving Medicaid waiver services using the policies and procedures in chapter M14.
- F. Long-term Care (LTC)** For long-term care recipients, eligibility must be redetermined at least once every twelve months. The DMAS-122 must be updated and sent to the provider or case manager whenever there is a change in income or deductions. The DMAS-122 must be updated at least every 12 months even if the patient's income or deductions do not change. If income and/or patient pay do not change, a currently dated DMAS-122 must be prepared and sent to the provider or case manager when the annual redetermination is completed.
- Review the recipient's SSN, program designation and TPL information in the MMIS to assure that they are correct.

G. Reports

Each local department will receive monthly eligibility review lists from the Medicaid enrollment and case management reports system. These lists will notify eligibility workers of their cases, which are due for review in the following months. An agency need not maintain a separate card file of eligibility reviews.

LOCAL CHOICE AGENCIES- 07/30/03

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

Roanoke Higher Education Authority
Round Hill, Town of
Saint Paul, Town of
Shenandoah County School Boards & County
South Central Wastewater Authority
Southampton County
Southampton County School Board
Spotsylvania County School Board
Sussex County School Board
Tazewell County
Tazewell County Department of Social Services
Tidewater Soil and Water Conservation District
Timberville, Town of
Urbanna, Town of
Virginia Biotechnology Research Park Authority
Virginia Dare Soil & Water Conservation District
Virginia Peninsulas Public Service Authority
Virginia Port Authority
Washington County School Board
Westmoreland County
Williamsburg-James City County Public Schools
Windsor, Town of
Wise County Board of Supervisors
Wise County School Board
Wise, Town of
Woodstock, Town of