



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

February 1, 2009

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #90

The following acronyms are used in this transmittal:

- ABD – Aged, Blind, Disabled
- AC – Aid Category
- ADAPT – Application Benefit Delivery Automation Project
- BRVS – Birth Record Verification System
- COLA – Cost of Living Adjustment
- CNNMP – Categorically Needy Non-money Payment
- CBC – Community-based Care
- DCSE – Division of Child Support Enforcement
- DMAS – Department of Medical Assistance Services
- DDS – Disability Determination Services
- DMHMRSAS – Department of Mental Health, Mental Retardation and Substance Abuse Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Level
- LDSS – Local Department of Social Services
- LTC – Long-term Care
- MI – Medically Indigent
- MMIS – Medicaid Management Information System
- PERM – Payment Error Rate Measurement
- QDWI – Qualified Disabled & Working Individuals
- SBP - Survivor Benefit Program
- SOF - Statement of Facts
- SPARK – Services Programs Answers Resources Knowledge
- SSI – Supplemental Security Income
- SSN – Social Security Number
- TANF – Temporary Assistance for Needy Families
- USCIS – United States Citizenship and Immigration Services

Medicaid Transmittal #90 contains revised, clarified, and updated Medicaid eligibility policy as outlined within this letter.

Revised Policy

The transmittal contains a change to the process for sending disability referrals to DDS. As announced in Broadcast #5258, effective October 31, 2008, DDS decentralized its operations, requiring referrals to be sent to the particular DDS regional office serving the local agency.

In this transmittal, policy was revised for the covered group of protected disabled widow(er)s age 50 through 64 years to distinguish between the age 50 through 59 group and the age 60 through 64 group. The distinction was made because the two groups are mandated by separate federal regulations.

This transmittal contains revisions to the policy requiring counting military retirement. Any portion of a military retiree's pension that is withheld as a contribution to participate in the SBP is excluded from income.

This transmittal contains revisions to the policy for counting life estates in real property. As announced in Broadcast #5187, effective September 19, 2008, life estates created on or after August 28, 2008, must be counted as resources and are subject to the same resource exclusions as real property. Life estates created prior to August 28, 2008 are not impacted by the revised policy and are not counted as resources, except when determining eligibility for QDWI.

Clarifications

This transmittal contains clarified policy regarding \$100 child support pass-through checks received by TANF recipients. Any amount of a pass-through check that exceeds \$50 must be counted as child support unearned income when determining Medicaid eligibility because the Medicaid child support income exclusion remains \$50 per month per assistance unit.

This transmittal also contains clarified policy requiring the evaluation of a pooled trust created for a disabled individual as an asset transfer. Effective July 1, 2008, funds placed in a pooled trust created for a disabled individual age 65 years or older are subject to evaluation as an uncompensated asset transfer when the individual has given up control of the funds. This policy also applies to additions to a pooled trust by an individual age 65 years or older when the trust was established prior to the individual's 65th birthday. This policy clarification was announced in Broadcast #5011.

In preparation for the federal PERM effort, and as a result of state Medicaid eligibility review projects, the case transfer policy has been clarified to require the sending LDSS to complete a renewal on a case before transferring it, when the renewal is past due or due in the month of transfer or the following month.

Other clarifications to policy contained in this transmittal include the following:

- Determining continued eligibility for an enrollee who applies for an SSN but does not provide the SSN at renewal;
- Use of actual income to determine F&C eligibility for the application month;
- Third party payments pending a support order;
- Undue hardship policy for MEDICAID WORKS;
- When the LTC asset transfer penalty period begins;

- Criteria for granting an undue hardship claim for a penalty period resulting from an uncompensated asset transfer; and
- The Hospice covered group renewal requirement to verify the enrollee's continued election and receipt of hospice services.

Updates

The SSI amounts, ABD deeming standard amount, ABD student child earned income exclusion, CBC personal maintenance allowance, spousal resource standard, spousal resource maximum, maximum monthly maintenance needs allowance, Medicare premiums, and COLA amounts for 2009 are included in this transmittal and were effective January 1, 2009, as announced in Broadcast #5307.

The updated LTC utility standard deduction, effective October 1, 2008, is also included in this transmittal. The updated amount was announced in Broadcast #5157. The utility standard deduction is used to determine if the community spouse's shelter expenses exceed the excess shelter standard.

The medically indigent income limits that are based on a percentage of the FPL are updated in this transmittal. These income limits were effective January 23, 2009, and announced in Broadcast #5387.

Effective Date

Unless otherwise specified in this transmittal letter, the policy revisions, clarifications and updates contained in this transmittal are effective for all eligibility determinations completed on or after February 1, 2009.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0110 pages 1, 2	Subchapter M0110 pages 1, 2	Page 1 is a runover page. On page 2, replaced "DMAS-122" with "patient pay."
Subchapter M0120 pages 9-12	Subchapter M0120 pages 9-12	Pages 9 and 12 are reprinted. On page 10, added the link for the online Application for Adult Medical Assistance. On page 11, added a reference to online applications.
Subchapter M0130 page 11	Subchapter M0130 page 11	On page 11, revised the policy for handling application withdrawals.
Chapter M02 Table of Contents	Chapter M02 Table of Contents	Updated the Table of Contents.
Subchapter M0220 pages 1-4b pages 4o-4r pages 19, 20 Appendix 1	Subchapter M0220 pages 1-4b pages 4o-4r pages 19, 20 Appendix 1	Page 1 is reprinted. On page 2, clarified that when an individual loses exception status to verifying citizenship & identity, his citizenship and identity must be verified by the next annual

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
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		<p>renewal, if not previously verified. Page 2a is a runover page. On page 3, replaced the manual Virginia birth record verification procedures with BRVS. Page 4 is a runover page. On page 4a, added ADAPT SOF to item 7 a. Page 4b is a runover page. On pages 4o and 4p, clarified requirement to verify citizenship & identity of individual who loses exception status and replace manual Virginia birth record verification references with references to BRVS. Page 4q is reprinted. On page 4r, deleted the monthly reporting requirement. Page 19 is reprinted. On page 20, state residency policy for non-immigrants is changed per Broadcast #5124. In Appendix 1, updated the contact information for the USCIS.</p>
Subchapter M0230 pages 1-4	Subchapter M0230 pages 1-4	On pages 1 and 3, state residency policy for non-immigrants is changed per Broadcast #5124. Pages 2 and 4 are reprinted.
Subchapter M0240 page 3	Subchapter M0240 pages 3, 4	On page 3, corrected lettering of section 4. On page 4, added procedures to follow at renewal when the enrollee does not provide a required SSN.
Subchapter M0280 Table of Contents pages 1-11 (all pages)	Subchapter M0280 Table of Contents pages 1-13 Appendix 1	Updated the Table of Contents. Page 1 is reprinted. On pages 2, 6, 7, 10, updated headers. On pages 3-5, consolidated institutional status policy from M1430. On page 8, added a reference to the new Appendix 1. On pages 8, 9 and 12, consolidated wording from M1430. On page 13, updated the reference to the Division of Benefit Programs.
Chapter M03 Table of Contents	Chapter M03 Table of Contents	Updated the Table of Contents.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0310 Table of Contents pages 25, 26	Subchapter M0310 Table of Contents pages 25, 26 Appendix 5	Updated the Table of Contents. On page 25, revised the instructions for where to send a disability referral. Page 26 is reprinted. Appendix 5, DDS Regional Offices, was added.
Subchapter M0320 Table of Contents pages 11-18 page 31, 32 pages 45-46d pages 47-50b pages 57, 58 pages 65, 66	Subchapter M0320 Table of Contents pages 11-18 page 31, 32 pages 45-46d pages 47-50b pages 57, 58 pages 65, 66	Updated the Table of Contents. On pages 11 and 12, updated the COLA and Medicare information for 2009. On pages 13 and 16, added policy on the group of Protected Disabled Widow(er)s Age 50-59 Years. Pages 14, 15, 17 and 18 are runover pages. On page 31, deleted reference to the DMAS-122 form and clarified the renewal requirement for ABD Hospice. Page 32 is reprinted. Page 45 is a runover page. On page 46, added information on the relationship between 1619(b) status and MEDICAID WORKS. On page 46a, updated the 1619(b) threshold amount for 2009. Page 46b and 46d are runover pages. On page 46c, clarified the process to be followed when the individual has good cause for unemployment. Page 47 is reprinted. On page 48, corrected the income limit for FAMIS MOMS. On page 49, removed obsolete policy on Plan First. Pages 50 and 50b are runover pages. On page 50a, removed the asset transfer requirement. On page 57, clarified the policy on special medical needs adoption assistance children. Page 58 is a runover page. On page 65, changed “program designation” to AC. On page 66, clarified the renewal requirement for F&C Hospice.
Subchapter M0520 pages 1, 2 pages 21, 22 pages 35, 36	Subchapter M0520 pages 1, 2 pages 21, 22 pages 35, 36	Page 1 is reprinted. On page 2, corrected a typographical error. Pages 22 and 35 are runover pages. On pages 21 and 36, corrected the number of trial visit months.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0530 Table of Contents pages 1, 2, 13 Appendix 1	Subchapter M0530 Table of Contents pages 1, 2, 13 Appendix 1	Updated the Table of Contents. On page 1, corrected a typographical error. Page 2 is reprinted. On page 13, deleted example. In Appendix 1, updated the ABD deeming allocations for 2009.
Subchapter M0710 pages 1-4 Appendices 6, 7	Subchapter M0710 pages 1-4 Appendices 6, 7	On page 1, corrected the last sentence. On pages 2 and 3, clarified available income. Page 4 is reprinted. In Appendix 6, updated the MI income limits. In Appendix 7, updated the Twelve Month Extended income limits.
Subchapter M0715 page 3	Subchapter M0715 page 3	Clarified that third-party payments made pending a support order are not counted as income.
Subchapter M0730 pages 7, 8	Subchapter M0730 pages 7, 8	Page 7 is reprinted. On page 8, added reference to the \$100 DCSE pass-through for TANF recipients.
Subchapter S0810 pages 1, 2	Subchapter S0810 pages 1, 2	On page 1, revised the income limits for the CNNMP Protected covered groups. On page 2, updated the 300% SSI and MI income limits for 2009.
Subchapter S0820 pages 29-32 pages 37, 38	Subchapter S0820 pages 29-32 pages 37, 38	Pages 29 and 32 are reprinted. On pages 30 and 31, updated the Blind or Disabled Student Child Earned Income Exclusion for 2009. On pages 37 and 38, corrected the header.
Subchapter S0830 pages 31, 32	Subchapter M0830 pages 31, 32	On pages 31 and 32, added the exclusion of the portion of a military retiree's pension withheld as a contribution to participate in the Survivor's Benefit Plan (SBP).
Subchapter S1110 pages 14,15	Subchapter S1110 pages 14,15	On page 14, clarified the policy for counting life estates as a resource. Page 15 is reprinted.
Subchapter S1130 pages 13, 14	Subchapter S1130 pages 13, 14	On page 13, clarified that life estate may be excluded under reasonable effort to sell provisions. Page 14 is reprinted.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter S1140 pages 11, 12 pages 19, 20	Subchapter S1140 pages 11, 12 pages 19, 20	On pages 11 and 12, clarified the policy for counting life estates as a resource. Page 19 is reprinted. On page 20, clarified required evidence for rebuttal of jointly owned bank accounts.
Chapter S11, Appendix 1 pages 1, 2 pages 17, 18	Chapter S11, Appendix 1 pages 1, 2 pages 17, 18	On pages 1 and 18, clarified the policy on counting life estates as a resource. Pages 2 and 17 are reprinted.
Subchapter M1370 pages 1-4	Subchapter M1370 pages 1-4	On page 1, clarified the spenddown periods for an ABD couple when only one spouse is MI. Pages 2-4 are runover pages.
Subchapter M1410 pages 1, 2	Subchapter M1410 pages 1, 2	On page 1, clarified that a hospice election in effect for 30 continuous days meets the definition of institutionalization. Page 2 is a runover page.
Subchapter M1420 Table of Contents pages 1-6 Appendices 1-3	Subchapter M1420 Table of Contents pages 1-6 Appendices 1-5	Updated the Table of Contents. On pages 1-6, clarified the pre-admission screening process for Medicaid-covered LTC services. Renumbered the existing appendices and added Appendix 1, the Medicaid Funded LTC Service Authorization Form (DMAS-96), and Appendix 2, the Technology Assisted Waiver Level of Care Form.
Subchapter M1430 Table of Contents pages 1-17 (all pages)	Subchapter M1430 Table of Contents pages 1-6 Appendix 1	Updated the Table of Contents. Reformatted the entire subchapter by deleting the section titled “Institutional Status;” this policy is in M0280. All headers were revised. On page 3, deleted the reference to section M1430.102. On page 4, added a reference to subchapter M0230. On page 5, deleted the “Institutional Status” section and changed the section number for “Advance Payments” to M1430.102. On page 6, changed the section number for “SSI Recipients” to M1430.103. Changed the page number of Appendix 1. Deleted Appendix 2; it was moved to M0280.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1440 pages 17, 18	Subchapter M1440 pages 17, 18	On page 17, removed the reference to the DMAS-122 form. Page 18 is reprinted.
Subchapter M1450 Table of Contents pages 15, 16 pages 23, 24 pages 35, 36 pages 39-43	Subchapter M1450 Table of Contents pages 15, 16 pages 23, 24a pages 35, 36 pages 39-42	Updated the Table of Contents. On page 15, added asset transfer policy on foreclosed homes. Page 16 is a runover page. On page 23, added asset transfer policy on pooled trusts. Pages 24 and 24a are runover pages. Page 35 is reprinted. On page 36, clarified when the penalty period begins. On pages 39-40a, clarified the criteria for granting an undue hardship claim. Pages 41 and 42 are runover pages.
Subchapter M1460 pages 19, 20 pages 35, 36	Subchapter M1460 pages 19, 20 pages 35, 36	On page 19, clarified the definition of institutionalization. Page 20 is a runover page. On page 35, revised the Blind or Disabled Student Child Earned Income Exclusion for 2008. Page 36 is reprinted.
Subchapter M1470 pages 21, 22	Subchapter M1470 pages 21, 22	On page 21, revised the basic maintenance allowance for 2008. On page 22, added the dollar amounts for the special earnings allowance.
Subchapter M1480 Table of Contents page 18c pages 19-20 pages 21, 22 pages 25, 26 pages 65, 66 pages 69, 70	Subchapter M1480 Table of Contents page 18c pages 19-20 pages 21, 22 pages 25, 26 pages 65, 66 pages 69, 70	Updated the Table of Contents. On page 18c, updated the spousal resource standards for 2008. On pages 19, 21 and 26, corrected references to other sections. Pages 20, 22 and 25 are reprinted. Page 65 is reprinted. On page 66, revised the utility standard deduction, effective October 1, 2008, and the maximum monthly maintenance needs allowance for 2009. On page 69, revised the basic maintenance allowance for 2009. On page 70, added the dollar amounts for the special earnings allowance.
Subchapter M1510 pages 7, 8	Subchapter M1510 pages 7, 8	On page 7, entitlement for individuals age 21-64 admitted to ineligible institutions is clarified. Page 8 is reprinted.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1520 Table of Contents pages 7-10a pages 15-22	Subchapter M1520 Table of Contents pages 7-10a pages 15-24	Updated the Table of Contents. On page 7, added the Hospice covered group renewal requirement. On pages 8 and 10, replaced “intranet” with “SPARK.” On page 9, updated the list of system matches requiring an advance notice. On page 10, changed reference to Medicaid computer to “MMIS.” On page 10a, revised the policy for handling requests for cancellation. On pages 15-20, clarified procedures for handling 12-month Extended Medicaid cases. On pages 21-24, clarified the case transfer policy and procedures.
Subchapter M1550 Appendix 1	Subchapter M1550 Appendix 1	Revised the contact information for the DMHMRSAS Facilities Medicaid Technicians.
Chapter M20 pages 3-6 pages 15, 16 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1	Chapter M20 pages 3-6 pages 15, 16 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1	On pages 3, 6, and 15, updated the Extra Help resource limits for 2009. Pages 4, 5 and 16 are reprinted. On page 1 of Appendices 1-4, updated the Extra Help resource and income limits for 2009. On page 1 of Appendix 3, also updated the Extra Help contributed food and shelter amounts for 2009. On page 1 of Appendix 4, also updated the subsidy benefit amounts for 2009.
Chapter M21 pages 1-4 Appendix 1	Chapter M21 pages 1-4 Appendix 1	Page 1 is reprinted. On pages 2-4, renumbered the section items, clarified that the Medicaid citizenship and identity verification requirements do not apply to FAMIS. Updated the FAMIS income limits in Appendix 1.
Chapter M22 pages 1-4 Appendix 1	Chapter M22 pages 1-4 Appendix 1	Page 1 is reprinted. On pages 2-4, clarified that the Medicaid citizenship and identity verification requirements do not apply to FAMIS MOMS. Updated the FAMIS MOMS income limits in Appendix 1.

This transmittal letter is the official record of changes made in Medicaid Transmittal #90 and should be used in conjunction with the transmittal. Should you have questions about information contained in this transmittal, please contact Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.


Anthony Conyers, Jr.
Commissioner

Attachment

M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

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

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

B. Legal Base

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

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

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities and for their enrollment in the Medicaid program.

C. Agency Responsibilities

1. DMAS

The administrative responsibilities of DMAS are:

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

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

2. DSS

The responsibilities of DSS are:

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

3. Confidentiality

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

a. Release of Client Information

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

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

b. Release of Information to Medical Providers

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

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Medicaid providers by DMAS or DSS without the applicant's/enrollee's consent. Enrollee consent is not needed for the agency to provide updated *patient pay* to a Medicaid provider or to provide confirmation

B. Application Forms

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

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

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

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

- 1. Application For Benefits**

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

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

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

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

5. **BCCPTA Medicaid Application** The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).
6. **ADAPT Statement of Facts** A signed ADAPT Statement of Facts (SOF) is a valid application for anyone in an ADAPT case, including ABD Medicaid applicants who are in an ADAPT case, EXCEPT for Plan First and BCCPTA. The SOF cannot be used as a Plan First or BCCPTA application. If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits or Eligibility Review Form Part B if that form was obtained for Food Stamps can be used to collect the additional information. The pages must be signed by the applicant and attached to the SOF.
7. **Title IV-E Foster Care & Medicaid Application/Redetermination** The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.
- For a IV-E FC child whose custody is held by a local department of social services or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636, is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and IV-E AA children, and for non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.
- For IV-E FC children in the custody of another state's social services agency and for IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.
8. **Application for Adult Medical Assistance** The Application for Adult Medical Assistance is intended for adults who are aged, blind or disabled or who need long-term care. *The paper form* is available online at: www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi. *The application may be completed and submitted online at:*

1. **Auxiliary Grant (AG)** An application for AG is also an application for Medicaid. A separate Medicaid application is not required.
2. **Plan First Application Form** The Plan First Application is for men and women who wish to apply for Medicaid coverage of family planning services only. Individuals who wish to apply for family planning services must complete and sign the Plan First Application. The Plan First Application form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.
3. **SLH Application Form** The following form has been prescribed as the application form for SLH:
 - Application for Benefits, form #032-03-824, also referred to as the Combined Application.

M0120.400 Place of Application

A. Principle

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

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

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

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

1. Foster Care

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

a. Title IV-E Foster Care

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

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

b. State/Local Foster Care

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

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

2. Adoption Assistance

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

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

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

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

C. Institutionalized Individual (Not Incarcerated)

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

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

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

D. Individuals in DMHMRSAS Facilities

1. Patient in a DMHMRSAS Facility

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

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

M0130.400 Applications Denied Under Special Circumstances

- A. General Principle** When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.
- B. Withdrawal** An applicant may withdraw his application at any time. The request *can be verbal or written*. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement *or by a verbal statement* specifically indicating the wish to withdraw the retroactive coverage part of the application.
- A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.*
- When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid *to the applicant*.
- C. Inability to Locate** The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.
- D. Duplicate Applications** Applications received requesting Medicaid and/or FAMIS for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A Notice of Action on Medicaid will be sent to the applicant when a duplicate application is denied.

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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non citizens of the UNITED STATES. These changes eliminated the permanently residing under color of law (PRUCOL) category of aliens. The level of Medicaid benefits for aliens is based on whether the alien is a “qualified” alien and the alien’s date of entry into the *United States*.

As a result of these federal changes in Medicaid eligibility for aliens, the 1997 Virginia General Assembly enacted legislation to protect Medicaid eligibility for certain aliens who would otherwise lose their Medicaid benefits.

This subchapter (M0220), effective on July 1, 1997, explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as “full benefit aliens”) or emergency services only (referred to as “emergency services aliens”). It contains the entitlement and enrollment procedures for full benefit aliens and emergency services aliens who meet all other Medicaid eligibility requirements.

B. Declaration of Citizenship/Alien Status

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

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

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

C. Procedures

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

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

M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

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

1. Citizenship and Identity Verification Required

The Deficit Reduction Act (DRA) of 2005 requires that effective July 1, 2006, all Medicaid applicants and enrollees who declared citizenship at the time of application, or for whom citizenship was declared at the time of application, present satisfactory evidence of citizenship and identity.

Non-IV-E Adoption Assistance children who apply for or receive Medicaid must have in their case record:

- a declaration of citizenship or qualified immigration status AND
- documentary evidence of the children's citizenship or declared qualified immigration status, and
- documentation of identity.

2. Exceptions to Verification Requirements

The citizenship and identity of the following groups of individuals do NOT need verification:

- a. all foster care children and IV-E Adoption Assistance children;
- b. newborns who meet the Medically Indigent (MI) Newborn Children in section M0320.301 or Medically Needy (MN) Newborn Children in section M0330.302, covered groups because a Medicaid application is not required for these newborns;
- c. Individuals entitled to or enrolled in Medicare, Social Security Disability Insurance (SSDI) beneficiaries and SSI recipients currently entitled to SSI payments (this does NOT include former SSI recipients) if the local department of social services (LDSS) has verification from the Social Security Administration (such as a SVES response) of the individual's Medicare enrollment, SSDI entitlement or current SSI recipient status.

When an individual loses the exception status, and his citizenship and identity has not previously been verified, it must be verified for him to remain eligible for Medicaid. See M0220.100 E.6.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for Medicaid for himself is NOT required to verify his or her citizenship and identity; the parent or caretaker must verify only the child's citizenship and identity, unless the parent signs an Affidavit of Citizenship on Behalf of Medicaid Applicants and Recipients attesting to a Medicaid applicant/recipient's citizenship.

B. Procedures

1. Individual Born in the United States

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

A child born to an emergency services alien mother, who is eligible only for Medicaid payment of her labor and delivery services, is deemed eligible for Medicaid as a "certain newborn" through age one as long as the child continues to reside with his mother and the mother and child continue to reside in Virginia. See M0320.301.

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

**2. Individual
Born Outside
the U.S.**

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

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

b. Individual Born to Naturalized Parents

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

c. Naturalized Individual

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

**3. Verification
Required One
Time**

At the time of application, the applicant must be given a reasonable opportunity to present documents establishing U.S. citizenship and identity. An individual who is active in Medicaid and who was enrolled in Medicaid prior to July 1, 2006, must present documentation of his citizenship and identity at the time of the first redetermination of eligibility occurring on or after July 1, 2006. Once documentation has been provided and recorded in the case record, it is not necessary to obtain documentation again. Documentary evidence may be accepted without requiring the applicant or recipient to appear in person.

C. Documents

Establishing U.S. Citizenship and Identity

1. Citizenship Document

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

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

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

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

2. Identity Document

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

3. Acceptable Documents

All documents must be either originals or copies certified by the issuing agency. Photocopies of original documents, including notarized copies, **are not** acceptable. The original must be viewed by the agency or other authorized staff and a copy made of the original; the copy must have written on it the date the original was seen and the name and title of the individual who saw the original. *See M0220.100 E. for details regarding which staff are authorized.*

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

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

4. Levels of Acceptable Documents

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

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

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

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

See M0220, Appendix 7 for information about the documents, the document issuer, and contact information for each document.

**5. How to Verify
Citizenship
and Identity**

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

**6. How to Verify
Citizenship**

If the individual does not have one of the Level 1 documents, ask if he has one of the Level 2 documents to prove citizenship. If the individual presents the original of one of the documents in Level 2, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the Level 2 documents, ask if he has one of the Level 3 documents to prove citizenship. If the individual presents the original of one of the documents in Level 3, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the Level 3 documents, ask if he has one of the Level 4 documents to prove citizenship, which includes a written affidavit. If the individual presents the original of one of the documents in Level 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not present one of the Level 4 documents to verify citizenship, he is not eligible for Medicaid because he has failed to provide documentary evidence of citizenship. **However, see section E that follows before denying or cancelling Medicaid because of failure to verify citizenship.**

NOTE: Naturalized citizens are limited to the documents in Level 1, Level 2 and the citizenship affidavit in Level 5 because they were not born in the United States. They should not have the documents listed in Levels 3 and 4, and they should not have any of the Level 5 documents except for the affidavit.

**7. How to Verify
Identity**

If the individual presents the original of one of the documents in Levels 2, 3, or 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

a. Children Under Age 16

A written affidavit for a child under age 16 may be used to verify the child's identity **if an affidavit was not used to prove the child's citizenship** and the identity affidavit language is not on the application, *ADAPT Statement of Facts (SOF)* or renewal form submitted by the individual. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf>.

The Health Insurance for Children and Pregnant Women application form, form number 032-03-0401, has been updated to include the identity affidavit language. The application form is available on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/famis.cgi>. The Families & Children Medicaid and FAMIS Plus Renewal form contains the identity affidavit language. The form is available on the intranet at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

b. Individuals Age 16 or Older

An affidavit of identity cannot be used for an individual age 16 or older, except when the individual resides in an institution. This form is available on SPARK at:

<http://spark.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi>. If the applicant is age 16 or older, the agency must assist the applicant in obtaining an identity document. If the individual does not present one of the documents in Chart 5 to verify identity, he is not eligible for Medicaid because he has failed to provide documentary evidence of identity. **See section E below before denying or cancelling Medicaid because of failure to verify identity.**

D. Hierarchy of Documentation

The agency's contact with the client about citizenship documents must follow the hierarchy of documentation. If the client does not have a Level 1, Level 2 or Level 3 citizenship document, the client must tell the agency why he or she cannot obtain these documents. The agency must write in the case record why the client cannot get Level 1, 2 or 3 document in order to explain why a Level 4 document was used (Level 4 includes the affidavits of citizenship).

NOTE: Applicants or recipients born outside the United States must submit a document listed under Level 1 - **primary evidence** of United States citizenship.

There is no hierarchy for the documentation of identity. For children under age 16, an affidavit of identity signed by the parent is acceptable whether or not other forms of identification may exist (see M0220.100 D.5 below).

1. LEVEL 1 – Primary Documents to Establish Both United States Citizenship and Identity

Level 1 primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a United States citizen. Obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in the Level 1 table as primary evidence of both United States citizenship and identity if the document meets the listed criteria and there is nothing indicating the person is not a United States citizen (e.g., lost United States citizenship).

NOTE: Persons born in American Samoa (including Swain's Island) are generally United States non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals.

NOTE: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by United States Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

Applicants or recipients born outside the United States who were not citizens at birth must submit a document listed under primary evidence of United States citizenship.

LEVEL 1 – Primary Documents	Explanation – Level 1
* United States Passport	<p>The Department of State issues this. A United States passport does not have to be currently valid to be accepted as evidence of United States citizenship, as long as it was originally issued without limitation.</p> <p>Note: Spouses and children were sometimes included on one passport through 1980. United States passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.</p> <p>Exception: Do not accept any passport as evidence of United States citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</p>
* Certificate of Naturalization (N-550 or N-570)	<p>Department of Homeland Security issues this document for naturalization. NOTE: A Certificate of Naturalization may not have a number on it. Form numbers N-550 and N-570 are no longer used. DHS now uses form number N-565. The application form for naturalization is now N-400.</p>

of important and possibly irreplaceable documents being misplaced or destroyed.

5. Birth Certificate Viewed By Out-of-State Agency

Local agencies are to accept copies of out-of-state birth certificates if the copies have statements on or attached to them that say the original birth certificates were viewed by staff of the issuing state's Department of Social Services or Medicaid state agency, and the statements are signed and dated by the issuing state's staff who viewed the originals.

6. Individuals Who No Longer Meet Exception

When an individual loses the exception status, and his citizenship and identity has not been previously verified, it must be verified for him to remain eligible for Medicaid. If the individual's eligibility in another covered group must be determined (due to the loss of SSI benefits, for example), obtain the documentation of citizenship and identity at the time of the eligibility review. If necessary, the processing time frame extension in M0220.100 E.11 may be allowed.

Verify the SSI recipient's or Medicare beneficiary's entitlement to benefits through SVES or SOLQ-I. A copy of the SVES or SOLQ-I printout must be placed in the case file.

7. Individual NOT Required to Submit Documents in Person

Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail-in the **original document** for the agency to copy and mail back to the individual, with the exception of a copy of a Virginia birth certificate which may be furnished rather than the original. The worker must write on the copy made for the case record that "the original document was viewed on (date) and the original was mailed back to the individual on (date)."

For individuals who need assistance securing a birth certificate, LDSS may request *Virginia birth record verification via BRVS* without receiving additional approval from the recipient beyond the recipient's original signature on the application for Medicaid. *If the result of a BRVS request is "unverified,"* however, the individual is to be notified that documentation of citizenship is needed and allowed the reasonable opportunity period to secure the documentation (see M0220.100 D.8 below).

8. Special Populations Needing Assistance

The agency shall assist special populations who need additional assistance, such as the homeless, mentally impaired, or physically incapacitated individual who lacks someone who can act on his behalf, to provide necessary documentation.

For individuals *born in Virginia* who are mentally impaired or physically incapacitated and lack someone who can act on their behalf, the agency should initiate action to secure the documentation for these individuals using the *BRVS* to request *Virginia birth verification*. *For individuals not born in another state, use the procedures* described in the *Procedures-Verifying Citizenship and Identity* document posted on *SPARK*.

9. Reasonable Opportunity to Verify Citizenship and Identity

Many individuals will be able to produce the required citizenship and identity verification requirements given the maximum amount of time allowed by processing time frames. Inquiries should be made to determine if they can produce the required documentation. LDSS agencies shall assist these individuals in helping to secure the required documentation by providing

information on what documentation is necessary and alerting them to agencies that may be contacted for the needed documentation.

The "reasonable opportunity period" permits exceptions from the standard time limits for processing applications when an applicant or recipient in good faith tries to present documentation, but is unable to do so because the documents are not available. In such cases, the agency should extend the application processing time limit and assist the individual in securing evidence of citizenship and/or identity.

If the individual cannot readily or easily produce citizenship documentation or it is a hardship to secure that documentation, secure the documentation for the individual *born in Virginia* using *BRVS*; use the process contained in the Procedures-Verifying Citizenship and Identity document posted on *SPARK* if the individual was born outside of Virginia.

If the individual, legal guardian or other responsible party indicates that additional time is required, allow a reasonable amount of additional time based on the time frames below.

10. Applicants - Extending the Processing Time Frames

Applicants, with the exception of those needing a disability determination, who have attempted to obtain citizenship and identity documentation will be given additional time beyond the normal time frame for processing applications (45 days for applications, 30 days for renewals) as follows:

a. Applicants Born in a State Other Than Virginia

An indefinite extension may be granted when out-of-state birth verification has been requested *but not received*. The status of the birth verification request must be documented in the case record until the required documentation is received.

b. Applicants Born in Virginia

For an applicant born in Virginia, the agency will, at the applicant's request, initiate a birth record verification request *using BRVS*. The turn-around time for the verification process is generally well within the standard application processing time; therefore, the reasonable opportunity period for applicants who were born in Virginia has not changed.

Applicants who were born in Virginia, with the exception of those needing a disability determination, who have attempted to obtain citizenship and identity documentation will be given an extension of 30 calendar days when the applicant has requested, but not received the required documents, or requested assistance in obtaining documents, as follows.

- An extension of 30 calendar days may be granted when the applicant/recipient has requested, but not received the required documents, or requested assistance in obtaining documents.
- An additional extension of up to 10 working days may be granted at the end of the 30-day extension when there is documentation that the information has been requested, but has not been received.

Because the processing time for applicants who require a disability determination remains 90 calendar days, which actually exceeds the extension periods listed above, **these applicants do not receive the extensions.**

Information regarding the need for the extension and agency's efforts to assist in helping obtain documentation must be included in the case file.

The worker should periodically review the status of the good faith effort and document the status in the case record until the required documentation is received. If the required information has not been received by the end of the extensions, appropriate action to deny coverage must be taken.

**11. Recipients -
Extending the
Processing Time
Frames**

For recipients of Medicaid, the processing time frame extension is indefinite, as long as

- a “good faith” effort continues to be made by the recipient, his authorized representative or other person(s) acting on the recipient’s behalf to obtain appropriate documentation of citizenship and identity, *and*
- *the recipient meets all other Medicaid eligibility requirements.*

The case record must be documented by the worker noting the attempts being made to secure the required verification. Providing all other Medicaid eligibility requirements are met, an existing Medicaid recipient’s case is allowed to remain open as long as a good faith effort is being made to obtain the verification.

**12. Failure to
Provide
Requested
Verifications**

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable time to present such documentation, is to result in the denial or termination of Medicaid.

An applicant or recipient who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by an applicant, recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period.

**13. Denial or
Cancellation
Action**

Local agencies must give the maximum allowable time for securing citizenship and identity verification permitted by the processing time frames and to pend cases of those individuals who are acting in good faith to secure the documentation not available through the agencies’ efforts.

Eligibility should only be denied or cancelled for lack of citizenship and/or identity verification reasons if there is clear and convincing evidence that the recipient has failed to present a good faith effort to produce the required documentation. Agencies are to recognize that, particularly for individuals who are aged, disabled and/or institutionalized, the intervention and assistance of authorized representatives may be needed to secure this information, and the maximum time and necessary assistance from the agency should be provided to the authorized representatives acting in good faith on behalf of the recipient.

A local agency is neither to deny nor terminate Medicaid eligibility based solely upon lack of citizenship or identity documentation without supervisory review and approval. An agency that has questions about a denial or a termination of eligibility should first consult the Medical Assistance Program Consultant assigned to the agency's service area.

14. Notification Requirements

Prior to the termination of benefits, the enrollee must be sent the Advance Notice of Proposed Action (Form 032-03-018) at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.

15. Maintain Documents in Case Record

The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.

16. No Reporting Requirements

There are no monthly reporting requirements. However, the Medical Assistance Program Consultants *may* conduct reviews of cases where Medicaid eligibility was denied or terminated because of lack of citizenship and/or identity verification.

17. Refer Cases of Suspected Fraud to DMAS

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

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

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in

M0220.411 UNQUALIFIED ALIENS

- A. Unqualified Aliens** Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** “grandfathered” aliens (M0220.314 above) are “unqualified” aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.
- B. Illegal aliens** Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.
- C. Non-immigrant Aliens** Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). Non-immigrants have the following types of *USCIS* documentation:
- Form I-94 Arrival-Departure Record,
 - Form I-185 Canadian Border Crossing Card,
 - Form I-186 Mexican Border Crossing Card,
 - Form SW-434 Mexican Border Visitor's Permit,
 - Form I-95A Crewman's Landing Permit.
- NOTE: If the alien remains in the U.S. after the limited time period (visa) is over, he becomes an illegal alien.
- Non-immigrants include:
1. **Visitors** visitors for business or pleasure, including exchange visitors;
 2. **Foreign Government Representative** foreign government representatives on official business and their families and servants;
 3. **Travel Status** aliens in travel status while traveling directly through the U.S.;
 4. **Crewmen** crewmen on shore leave;
 5. **Treaty Traders** treaty traders and investors and their families;
 6. **Foreign Students** foreign students;
 7. **International Organization** international organization representatives and personnel, and their families and servants;
 8. **Temporary Workers** temporary workers including some agricultural contract workers;
 9. **Foreign Press** members of foreign press, radio, film, or other information media and their families.

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

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

1. Residency the Virginia residency requirements (M0230);

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

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

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

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) OFFICE

All agencies needing to correspond with USCIS are to use the following address:

*Status Verification Operations Branch MS 2630
U.S. Citizenship and Immigration Services
2221 South Clark Street
Arlington, VA 22202*

toll-free phone: 1-888-464-4218

M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

M0230.001 POLICY PRINCIPLES

- A. Policy** An individual must be a Virginia resident in order to be eligible for Medicaid, but is not required to have a fixed address. This subchapter, M0230, explains in detail how to determine if an individual is a Virginia resident.
- An individual placed by a Virginia government agency in an institution is considered a Virginia resident for Medicaid purposes even when the institution is in another state (section M0230.203 below).
- For all other individuals, Virginia residency is dependent on whether the individual is under age 21 years or is age 21 or older (sections M0230.201 and 202 below).
- B. Retention of Residency** Residence is retained until abandoned. Temporary absence from Virginia with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Virginia residence.
- C. Non-immigrant Aliens** Aliens who are non-immigrants (visitors, temporary workers) *usually do not meet the Virginia state residency requirements because their visas will expire on a definite date. Ask the non-immigrant alien "Where do you intend to live after your visa expires?" If the non-immigrant alien states in writing that he "intends to reside in Virginia permanently or indefinitely after his visa expires," then the non-immigrant alien has stated his intent to reside in Virginia permanently or indefinitely and can meet the Virginia residence eligibility requirement for Virginia Medicaid.*
- D. Cross-Reference to Intra-State Transfer** Procedures for handling cases where individuals who are Virginia residents move from one Virginia locality to another are described in subchapter M1520.
- E. No Fixed Address** The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.
- For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he must come to the social services department to receive his card until he obtains a fixed address.
- F. Length of Residency** The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.
- G. Residency in Virginia Prior to Admission to Institution** The agency may not deny Medicaid eligibility to an individual in an institution who meets the Virginia residency requirements previously identified in this subchapter, because the individual did not establish residence in Virginia before entering the institution.

- H. Temporary Absence** The agency may not deny or terminate Medicaid eligibility because of that individual's temporary absence from Virginia if the individual intends to return to Virginia when the purpose of the absence has been accomplished, UNLESS another state has determined that the individual is a resident there for Medicaid purposes.
- I. Disputed or Unclear Residency** If state residency is unclear or is in dispute, contact the regional specialist for help in resolution. When two or more states cannot resolve the residency, the state where the individual is physically located becomes the state of residence.

M0230.100 DEFINITION OF TERMS

- A. Introduction** For purposes of this subchapter only, the terms in this section have the following meanings:
- B. Institution** An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.
- For purposes of state placement of an individual, the term "institution" also includes foster care homes approved by the state and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.
- C. In An Institution** "**In an institution**" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.
- D. Incapable of Indicating Intent** An individual is incapable of declaring his intent to reside in Virginia or any state if the individual:
- has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Virginia Department of Mental Health Mental Retardation & Substance Abuse Services (DMHMRSAS);
 - is judged legally incompetent; or
 - is found incapable of declaring intent to reside in a specific state based on medical documentation obtained from a physician, psychologist, or other professional licensed by the State in the field of mental retardation.
- E. Virginia Government Agency** A Virginia government agency is any state or local government agency, and any entity recognized by State law as being under contract with a Virginia state or local government agency.

M0230.200 RESIDENCY REQUIREMENTS

M0230.201 INDIVIDUALS UNDER AGE 21

A. Under Age 21 NOT In An Institution

1. Blind or Disabled

For any individual under age 21

- who is not residing in an institution (as defined above in M0230.100)
AND
- whose Medicaid eligibility is based on blindness or disability,

the state of residence is the state in which the individual is living. If the individual lives in Virginia, he/she is a Virginia resident.

2. Other Individuals Under Age 21

An individual under age 21 who is **not** in an institution is considered a resident of Virginia if he/she:

- a. is married or emancipated from his/her parents, is capable of indicating intent and is residing in Virginia with the intent to remain in Virginia permanently or for an indefinite period;
- b. is presently living in Virginia on other than a temporary basis;
- c. lives with a caretaker who entered Virginia as a result of a job commitment or a job search (whether or not currently employed) and is not receiving assistance from another state;
- d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);
- e. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);
- f. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;
- g. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.
- h. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, and no other information is contrary to the stated intent.

**B. Under Age 21 In
An Institution**

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or
3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the party who files the Medicaid application resides in Virginia.
4. for an individual under 21, if a legal guardian has been appointed for the child and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

**C. Under Age 21,
Custody or
Adoption
Agreement with
Another State**

When another state's child-placing agency has custody of a child who lives in Virginia with a foster family, the child is NOT a Virginia resident unless the child is eligible as a IV-E Foster Care child and receives a IV-E Foster Care maintenance payment.

**1. IV-E Eligible
Children**

A Title IV-E Foster Care child who lives in Virginia and who receives a Title IV-E maintenance payment from another state meets the Virginia residency requirements for Medicaid.

A Title IV-E Adoption Assistance child who lives in Virginia and has a Title IV-E Adoption Assistance agreement in effect with another state's child-placing agency meets the Virginia residency requirements for Medicaid.

**2. Non-IV-E
Foster Care**

A non-IV-E Foster Care child placed in Virginia from another state does NOT meet the Virginia residency requirements for Medicaid.

**3. Non-IV-E
Adoption
Assistance and
Adoptive
Placement**

A child who lives in Virginia with an adoptive family is considered to be living with a parent, regardless of whether a final order of adoption has been entered in court. When his adoptive parent is a Virginia resident, the child is a Virginia resident for Medicaid eligibility purposes. A Non-IV-E Adoption Assistance child whose adoption assistance agreement is signed by another state's child-placing agency is a Virginia resident when the child lives in Virginia with the adoptive parent(s).

For example, an individual applied for an SSN on October 13, 2006. Enter “APP101306” as the individual’s SSN.

When enrolling an eligible individual in MMIS, use the date the individual applied for an SSN, or the individual’s date of birth, preceded by “888.”

3. Follow-up

a. Follow-up in 90 Days

After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

b. Check for Receipt of SSN

Check the MMIS and ADAPT records for the enrollee’s SSN. If the SSN still has “888” or “APP” as the first 3 digits, contact the enrollee to obtain the enrollee’s SSN verbally or by mail.

c. Verify SSN

Verify the SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in Systems

Enter the enrollee’s SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

4. Renewal Action

If the enrollee’s SSN has not been assigned by the 90-day follow-up, the worker must follow-up no later than the enrollee’s annual renewal, by checking the systems for the enrollee’s SSN and by contacting the enrollee if necessary.

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into MMIS and ADAPT. Check the MMIS and ADAPT records for the enrollee’s SSN. If the SSN has “888” or “APP” as the first 3 digits, contact the enrollee to obtain the enrollee’s SSN verbally or by mail, or on the renewal form if a renewal form is required.

b. Verify SSN

Verify the SSN by a computer system inquiry of the SSA records.

c. Enter Verified SSN in Systems

Enter the enrollee’s SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

d. SSN Not Provided by Renewal Deadline

The worker must assist the enrollee in obtaining the applied-for SSN. The worker will ask the enrollee for the assigned SSN at the first renewal, and give a deadline date for the enrollee to provide the SSN.

If the enrollee does not provide the SSN by the deadline, the worker will ask the enrollee why it was not provided to the worker:

- *Did the enrollee ever receive the SSN from SSA?*
- *If not, why not?*

If the problem is an SSA administrative problem, such as a backlog of SSN applications causing the delay in issuing an SSN to the enrollee, the enrollee continues to meet the Medicaid SSN eligibility requirement. The worker will assist the enrollee with obtaining the SSN and will periodically check with the computer systems and the enrollee.

*If the problem is **not** an SSA administrative problem, the worker must cancel Medicaid coverage for the enrollee whose SSN is not provided.*

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M0280.000 INSTITUTIONAL STATUS REQUIREMENTS**M0280.001 GENERAL PRINCIPLES**

- A. Introduction** To be eligible for Medicaid, an institutionalized individual must meet the institutional status requirement. An individual does not necessarily have to live in an institution to be considered an "inmate of a public institution." Inmates of public institutions are NOT eligible for Medicaid.
- B. Procedure** This subchapter, M0280, contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether an individual meets the Medicaid institutional status eligibility requirement.

Refer to M0520.001 for the policy and procedures for determining the assistance unit size for children in medical institutions or residential treatment facilities.

M0280.100 DEFINITION OF TERMS

- A. Child Care Institution** A child care institution is a
- non-profit private child-care institution, or
 - a public child care institution that accommodates no more than 25 children which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.
- The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.
- B. Facility for the Mentally Retarded** A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.
- C. Institution** An institution is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.
- D. Institution for the Treatment of Mental Diseases (IMD)** An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A facility for the mentally retarded is NOT an IMD.
- E. Medical Facility** A medical facility is an institution that:
- is organized to provide medical care, including nursing and convalescent care,

- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

**F. Public Institution
(Facility)**

A public institution is an institution (facility) that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, and which is NOT a medical facility.

The following are NOT public facilities for this section's purposes:

- a medical facility, including a nursing facility;
- a publicly operated community residence (serves no more than 16 residents);
- a child care institution, for children who receive foster care payments under Title IV-E or AFDC foster care under Title IV-A, that accommodates no more than 25 children;
- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

**G. Publicly Operated
Community
Residence**

A publicly operated community residence is a public residential facility (institution) with 16 beds or less, that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though these facilities have 16 or less beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;
- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;
- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent;
- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there.

NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence.

H. Residential Institution

An institution that does not meet the definition of a “medical facility.”

M0280.200 INSTITUTIONAL STATUS RULE

A. Introduction

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

1. individuals who are **inmates of a public institution**.
2. individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. NOTE: an ICF-MR is not an IMD.

B. Procedures

The policy and procedures for determining whether an individual is in an IMD are contained in subchapter M1430.

The policy and procedures for determining whether an individual is an inmate of a public institution are contained in the following sections:

- M0280.201 Individuals in Medical Facilities
- M0280.202 Individuals in Residential Facilities
- M0280.300 Inmate of A Public Institution
- M0280.301 Who Is NOT An Inmate of A Public Institution
- M0280.400 Procedures For Determining Institutional Status
- M0280.500 Individuals Moving To or From Public Institutions
- M0280.600 Departmental Responsibility.

M0280.201 INDIVIDUALS IN MEDICAL FACILITIES

A. Public or Private

The public or private ownership or administration of a **medical** facility is irrelevant because a medical facility is not a public institution as defined in this subchapter.

B. Incarcerated Individual Not Eligible

To be eligible for Medicaid, an institutionalized individual in a medical facility must meet the institutional status requirement. A medical facility is NOT a public institution even if it is administered by a governmental unit.

However, an individual who resides in a medical facility may be considered an inmate of a public institution because he is incarcerated, as defined in this subchapter. If a medical facility patient is incarcerated, he is an inmate of a public institution and is not eligible for Medicaid.

C. Individuals in IMDs

The following individuals in public or private IMDs are NOT eligible for Medicaid because they do not meet the institutional status requirement:

- *an individual who is age 22 or over, but under age 65;*
- *an individual who is under age 22 who is NOT receiving inpatient psychiatric services in the IMD.*

An individual is in an IMD from the date of admission to the IMD until discharge from the IMD.

1. Eligible Patient In An IMD

An individual is in an IMD when he/she is admitted to live there and receive treatment or services provided there that are appropriate to his/her requirements. A patient in an IMD is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain.

An individual who is age 65 or older and who is a patient in a public or private IMD meets the institutional status requirement for Medicaid. An individual who is under age 22, who is a patient in a public or private IMD and who is receiving inpatient psychiatric services in the IMD meets the institutional status requirement for Medicaid.

2. Conditional Release From IMD

A patient in an IMD who is transferred or discharged to a medical facility that is not an IMD, including a patient under conditional release or convalescent leave from the IMD, meets the institutional status requirement and may be eligible for Medicaid.

D. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined in this subchapter.

E. Residential Facilities With Certified Medical Beds

Some institutions have both medical and residential sections. Individuals in the residential section (or beds) are residents of a residential facility. If the resident receives Medicaid Community-based Care (CBC) waiver services, use Chapter M14 to determine the individual's eligibility. If the resident does not receive Medicaid CBC, he is not in long-term care; use the Medicaid eligibility requirements for non institutionalized individuals.

Individuals in the medical certified portion (or beds) of an institution are patients in a medical facility. Use Chapter M14 in determining their Medicaid eligibility.

F. District Homes

The District Homes are public institutions that serve more than 16 residents. A District Home may have a portion of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas.

Patients in the certified nursing facility portion of the District Home meet the institutional status requirement, unless they are incarcerated or are juveniles in detention as defined in this subchapter.

Residents in the residential portions of the District Homes are inmates of a public institution and are not eligible for Medicaid because the residential portion is a public residential facility of more than 16 beds.

G. Cross Reference

If the individual has been, or is expected to be, in the medical facility or medical section of the facility for 30 or more consecutive days, the individual is receiving long-term care. *Chapter M14 contains additional eligibility policy for individuals in long-term care.*

M0280.202 INDIVIDUALS IN RESIDENTIAL FACILITIES

A. Institutions With Medical and Residential Sections

1. Some institutions have both medical and residential sections. An individual in the medical certified section (or beds) of the institution is a patient in a medical facility. If the individual has been, or is expected to be, in the medical facility for 30 or more consecutive days, the individual is receiving long-term care. Go to New Volume XIII Chapter M1400 to determine the individual's eligibility.
2. An individual in the residential portion (or beds) of the institution is a resident of a residential facility. Use this subchapter to determine the resident's institutional status.

B. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. **A group home that has three or less residents is not an institution.**

However, the individual may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as described below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status eligibility requirement.

C. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

D. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

1. the public residential facility has more than 16 beds, or
2. the individual is an inmate - an incarcerated adult or a juvenile in detention - as described in section M0280.300 below, and is not an individual listed in M0280.301 below.

M0280.300 INMATE OF A PUBLIC INSTITUTION**A. Policy**

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated individuals;
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. For example, an individual released from jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is still considered incarcerated and is an inmate of a public institution. An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

1. District or County Homes

The District Homes or County Homes are public residential facilities that serve more than 16 residents. A District or County home may have other portions of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas. There is one county home - the Orange County Home.

Residents in the residential portions of the District or County Homes are inmates of a public institution and are not eligible for Medicaid because the residential portion is a public institution of more than 16 beds and does not meet the definition of a publicly operated community residence.

Patients in the certified nursing facility portion of the District or County Home are NOT inmates of a public institution because that portion is a medical facility. Patients in the nursing facility portion of the District or County Home meet the institutional status requirement and may be eligible for Medicaid.

2. Ineligible Public Residential Facilities

A public residential facility that does not meet the definition of a “publicly operated community residence” in section M0280.100 above, is an “ineligible public institution.” Public residential institutions with more than 16 beds are ineligible public institutions. The following public institutions are ineligible public institutions even though these facilities have 16 or less beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;
- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;
- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent.

**C. Incarcerated
Individuals**

An incarcerated individual is an inmate of a public institution, even when he/she is in a medical facility. The key element is whether the incarcerated individual resided in a jail or prison immediately prior to admission to the medical facility. The following incarcerated individuals are inmates of a public institution:

1. Prison Inmate

An inmate in a prison is not eligible for Medicaid.

2. Jail Inmate

An inmate in a county or city jail is not eligible for Medicaid.

**3. Prison or Jail
Inmate**

An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid. An inmate may be eligible if he/she is out on bail or released on his/her own recognizance.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and is not eligible for Medicaid.

4. Work Release

An individual who is incarcerated but can leave the prison, jail or work release center on work release or work furlough and must return to prison or jail at specific intervals is NOT eligible for Medicaid.

**5. Released on
Medical
Emergency**

An individual released from prison or jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is not eligible for Medicaid.

**D. Juveniles in
Detention**

In determining whether a juvenile (individual under age 18 years) is incarcerated and an inmate of a public institution, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post-disposition situations, and types of facilities.

**1. Prior to Court
Disposition**

- 1) A juvenile who is in a detention center due to criminal activity is an inmate of a public institution. Incarceration in a detention center due to criminal activity makes the individual an inmate of a public institution. The length of stay in the detention center is irrelevant. A short incarceration in a detention facility is NOT temporary placement pending other arrangements.

A juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed, is an inmate of a public institution.

- 2) A juvenile who is in a detention center due to care, protection or in the best interest of the child is NOT an inmate of a public institution.

2. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution. *See Appendix 1 to this subchapter for a list of secure detention facilities in Virginia.*

If they go to a nonsecure group home, they are NOT inmates of a public institution because a nonsecure group home is not a detention center.

3. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible if he/she is a resident of an ineligible public residential facility.

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the facility (a detention center is a public institution) he is not eligible for Medicaid during the period of incarceration. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for Medicaid.

4. Ineligible Juveniles in Detention

The following juveniles in detention are inmates of a public institution and are not eligible:

- a. A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity is not eligible for Medicaid.
- b. A minor placed on probation by a juvenile court with specific conditions of release, including residence in a secure juvenile detention center is not eligible for Medicaid.

M0280.301 WHO IS NOT AN INMATE OF A PUBLIC INSTITUTION

A. Who Is NOT An Inmate of a Public Institution

An individual is NOT an inmate of a public institution if

- *he is in a public educational or vocational training institution for purposes of securing education or vocational training OR*
- *he is in a public institution for a temporary period pending other arrangements appropriate to his needs.*

- B. Educational or Vocational Institution** An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.
- C. Temporary Stay** An individual residing in a public institution for a temporary period pending other arrangements appropriate to his needs is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.
- D. Admitted Under TDO** An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.
- E. Arrested Then Admitted to Medical Facility** An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard is NOT an inmate of a public institution and may be eligible for Medicaid. *He is not an inmate of a public institution because he did not reside in a jail, prison or secure detention facility immediately prior to admission to the medical facility.*
- F. Inmate Out On Bail** An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid unless he/she is out on bail or released on his/her own recognizance.
- G. Probation, Parole, or Conditional Release** An individual released from prison or jail on probation, parole, or release order with a condition of:
- home arrest
 - community services
 - outpatient treatment
 - inpatient treatment
- is not an inmate of a public institution and may be eligible for Medicaid.
- An individual released from prison or jail under a court probation order due to a medical emergency is NOT an inmate of a public institution and may be eligible for Medicaid.
- H. Juvenile in Detention Center Due to Care, Protection, Best Interest** A minor in a juvenile detention center prior to disposition (judgement) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.
- This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.
- I. Juvenile on Probation in Secure Treatment Center** A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

- J. Juvenile On Conditional Probation** A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient is NOT an inmate of a public institution and may be eligible for Medicaid.
- However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is NOT eligible for Medicaid.
- K. Juvenile On Probation in Secure Treatment Center** A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.
- L. Juvenile On Conditional Probation** A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid. However, if the juvenile is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is not eligible for Medicaid.

M0280.400 PROCEDURES FOR DETERMINING INSTITUTIONAL STATUS

- A. Procedures** In this order, determine:
- B. Is the Individual In An Institution?** Ask: is the individual living in a home or establishment that provides food, shelter and some services to four or more persons unrelated to the proprietor?
1. If NO, the individual is not in a facility. Individual meets the institutional status eligibility requirement for Medicaid. STOP.
 2. If YES, the individual is in a facility. Go to item C. below.
- C. Is the Individual Incarcerated?** Is the individual incarcerated and an inmate of a public institution? Ask the following questions:
- Was he in a secure facility (jail, prison, secure detention) immediately before admission?
1. If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.
 2. If YES, ask: is he a juvenile (under age 18)?
 - a. NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.
 - b. YES: Ask: Is this facility a secure treatment facility?
 - 1) NO: Ask: Was he in a juvenile detention center prior to admission due to criminal activity?

- a) NO: he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.
- b) YES: Ask: Was he placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient?
 - (1) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.
 - (2) YES: he is not an inmate of a public institution and may be eligible for Medicaid. *Go to D, below.*
- 2) YES: Ask: Is the secure treatment facility part of the criminal justice system?
 - a) NO: he is NOT an inmate of a public institution and may be eligible for Medicaid. *Go to D, below.*
 - b) YES: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

D. Is the Facility Medical?

Ask: is the institution, or portion of the institution, in which the individual resides a medical facility?

- 1. *If NO, the facility is residential. Go to item F below.*
- 2. *If YES, the individual is in a medical facility. Go to item E, below.*

E. Is the Medical Facility an IMD?

Ask: is the medical facility an IMD?

- 1. *NO: the individual is not in an IMD and meets institutional status requirement for Medicaid.*
- 2. *YES: Ask: is the individual age 65 or older?*
 - a. *NO: is the individual under age 22?*
 - (1) *NO: he is an ineligible IMD patient and is NOT eligible for Medicaid. STOP.*
 - (2) *YES: is he receiving inpatient psychiatric treatment in the IMD?*

(a)NO: he is an ineligible IMD patient and is NOT eligible for Medicaid. STOP.

(b)YES: he is an eligible IMD patient and may be eligible for Medicaid. STOP.

b. YES: he is an eligible IMD patient and may be eligible for Medicaid. STOP.

F. Is the Individual in a Public Residential Institution?

Determine if the residential facility is a public institution as defined above.
Ask: is the residential facility public?

1. *If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid.*
2. *If YES, ask: how many beds does it have?*
 - a. *If it has 16 beds or less, he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.*
 - b. *If it has more than 16 beds, the individual DOES NOT meet the institutional status requirement and is not eligible for Medicaid. STOP.*

M0280.500 INDIVIDUALS MOVING TO OR FROM PUBLIC INSTITUTIONS

A. Moves To Public Institution

If a currently eligible recipient is incarcerated or enters an ineligible institution, he is no longer eligible for Medicaid. Outstanding bills for covered medical services incurred prior to his admission and during his Medicaid coverage period will be paid.

B. Moving From Public Institution

Although a person may not be eligible for Medicaid while living in a specified public institution or part thereof, he may apply for such assistance as a part of prerelease planning. If he is found eligible (except for institutional status), do not enroll until he leaves the institution to live elsewhere.

C. Resident Admitted to Medical Facility

A resident of an ineligible public institution, or an inmate of a public institution, who is admitted to a medical institution (general hospital or nursing facility) for inpatient care is NOT eligible for Medicaid during the period of care in the medical institution because his institutional status does not change when he is admitted to the medical facility. He is still considered an inmate of a public institution.

M0280.600 DEPARTMENTAL RESPONSIBILITY**A. DMHMRSAS****Patients****1. ABD Covered
Groups**

Medicaid eligibility of patients who are:

- in State-owned Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) institutions for the treatment of mental disease and mental retardation,
- not currently enrolled in Medicaid, and
- eligible in an Aged, Blind, or Disabled (ABD) covered group

is determined by the Medicaid Technician staff of the Division of *Benefit* Programs, Department of Social Services, who also carries responsibility for enrollment. (See subchapter M1550).

**2. F&C
DMHMRSAS
Patients**

Local social services departments continue to carry responsibility for the determination of eligibility for Medicaid of a child eligible in a Families and Children's covered group who have been admitted to a DMHMRSAS institution for treatment of the mentally retarded, and for the child's enrollment in Medicaid.

**B. All Other
Institutions**

Local social services departments carry responsibility for the Medicaid eligibility determination and enrollment of individuals in institutions that are not operated by DMHMRSAS. The local DSS agency in the Virginia locality where the individual last resided outside of an institution is the responsible DSS agency. If the individual resided outside of Virginia immediately before admission to the institution, the responsible local DSS is the DSS agency serving the locality where the institution is located.

When a local department carries responsibility for eligibility determination and enrollment of an individual living in an institution, the department is also responsible for:

- advising the institution of the individual's eligibility for Medicaid and enrollment in the program;
- submitting a DMAS-122 form to the institution to indicate current patient pay, if applicable; *and*
- seeing that the Medicaid card is forwarded to the institution for the *enrollee's* use.

List Of Secure Juvenile Detention Facilities In Virginia

Superintendent
Chesterfield Detention Home
9780 Krause Road
Chesterfield, VA 23832

Director of Detention Services
Crater Youth Care Commission
6102 County Drive
Disputanta, VA 23842

Superintendent
Fairfax Detention Home
10650 Page avenue
Fairfax, VA 22030

Superintendent
Henrico Detention Home
P.O. Box 27032
Richmond, VA 23273

Superintendent
Highlands Juvenile Detention Home
P.O. Box 248
Bristol, VA 24203

Superintendent
Loudoun Detention Home
42020 Loudoun Center Place
Leesburg, VA 22075

Superintendent
Lynchburg Juvenile Detention Home
1400 Florida Avenue
Lynchburg, VA 24501

Superintendent
New River Valley Juvenile Detention Home
650 Wades Lane, N.W.
Christiansburg, VA 24073

Superintendent
Newport News Detention Home
228 15th Street
Newport News, VA 23607

Superintendent
Norfolk Detention Home
1313 Child Care Court
Norfolk, VA 23502

Superintendent
Northern Virginia Detention Home
200 S. Whiting Street
Alexandria, VA 22304

Superintendent
Prince William Detention Home
14873 Dumfries Road
Manassas, VA 22110

Superintendent
Rappahannock Detention Home
400 Bragg Hill Drive
Fredericksburg, VA 22401

Superintendent
Richmond Detention Home
2100 Mecklenburg Street
Richmond, VA 23223

Superintendent
Roanoke Juvenile Detention Home
4345 Coyner Springs Road
Roanoke, VA 24012

Superintendent
Shenandoah Valley Juvenile Detention Home
1110 Montgomery Avenue
Staunton, VA 24401

Superintendent
Tidewater Detention Home
420 Albemarle Drive
Chesapeake, VA 23320

Superintendent
W.W. Moore Home for Juveniles
603 Colquohoun Street
Danville, VA 24541

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1. DSS Referrals to DDS

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

- [Disability Report Adult SSA-3368-BK](#) (see Appendix 1 to this subchapter) or the [Disability Report Child SSA-3820-BK](#), (see Appendix 2 to this subchapter); and
- a minimum of 5 signed, original forms: [Authorization to Disclose Information to the Social Security Administration form SSA-827-02-2003](#) (see Appendix 3 to this subchapter) **or** 1 for each medical provider if more than 5; and
- a DDS Referral Form #032-03-0095, available on the intranet at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

NOTE: the applicant may have a hard (printed) copy of an on-line Disability Report used to apply for Social Security benefits. A hard copy of the SSA on-line Disability Report for Adults (3368PRO) or Children (3820) may be accepted in lieu of the SSA-3368-BK or SSA-3820-BK; however, an individual cannot submit an actual on-line Disability Report to DDS for Medicaid disability determination purposes.

When the SSA disability report and the Authorization to Disclose Information to the Social Security Administration forms must be sent to the applicant for completion, send the request immediately, giving the applicant 10 calendar days to return the completed forms. When the completed forms are returned, mail them along with the DDS Referral Form to the *DDS Regional Office to which the local DSS agency is assigned. The addresses for the DDS Regional Offices and their assigned local agencies are contained in M0310, Appendix 5.*

Do not send referrals to DDS via the courier.

The eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed as soon as the decision on the disability determination is received.

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

2. Nonfinancial Requirements

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

F. Communication Between Agency and DDS

1. Agency

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

If the *agency* is aware of changes in the applicant's situation that would make him ineligible for Medicaid even with a favorable disability determination, the information must immediately be provided to the DDS so that office will not complete a disability determination. The fact that an individual has excess resources is not a reason for DDS to stop the development of a disability claim (see M0130.100.B.4).

When an application is denied for a nonfinancial reason not related to the disability determination, DDS must be notified immediately.

2. DDS Responsibilities

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited (within 7 working days) disability determination, DDS will fax the outcome of the disability determination decision to the *agency*. For all other disability determinations, DDS will send the *agency* a notice to be sent to the applicant advising him of the outcome of his disability determination.

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

DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals division so that the appeal may be closed (see M1650.100).

G. Notice to the Applicant

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

H. Applicant is Deceased

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

DDS Regional Offices

Send all non-expedited disability referrals to the DDS Regional Office to which the local DSS agency is assigned, as indicated in the table below.

DDS Regional Office	Local DSS Agency Assignments
<p>Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233</p> <p>Phone: 800-523-5007 804-367-4700 FAX: 866-323-4810</p>	<p>Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greensville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex</p>
<p>Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502</p> <p>Phone: 800-379-4403 757-466-4300 FAX: 866-773-0244</p>	<p>Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York</p>
<p>Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030</p> <p>Phone: 800-379-9548 703-934-7400 FAX: 866-843-3075</p>	<p>Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester</p>
<p>Southwest Regional Office Disability Determination Services 111 Franklin Road, S.E., Suite 250 Roanoke, Virginia 24011</p> <p>Phone: 800-627-1288 540-857-7748 FAX: 866-802-5842</p>	<p>Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe</p>

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The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

- 1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a CNNMP former SSI recipient.

The non-protected spouse's eligibility is evaluated in another covered group.

- 2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.
- 3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

4. COLA Formula

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Cost-of-living calculation formula:

$$\text{a. } \frac{\text{Current Title II Benefit}}{1.058 \text{ (1/09 Increase)}} = \frac{\text{Benefit Before}}{1/09 \text{ COLA}}$$

- b. $\frac{\text{Benefit before 1/09 COLA}}{1.023 \text{ (1/08 Increase)}} = \text{Benefit Before 1/08 COLA}$
- c. $\frac{\text{Benefit Before 1/08 COLA}}{1.033 \text{ (1/07 Increase)}} = \text{Benefit Before 1/07 COLA}$
- d. $\frac{\text{Benefit Before 1/07 COLA}}{1.041 \text{ (1/06 Increase)}} = \text{Benefit Before 1/06 COLA}$
- e. $\frac{\text{Benefit Before 1/06 COLA}}{1.027 \text{ (1/05 Increase)}} = \text{Benefit Before 1/05 COLA}$
- f. $\frac{\text{Benefit Before 1/05 COLA}}{1.021 \text{ (1/04 Increase)}} = \text{Benefit Before 1/04 COLA}$

Contact a Medical Assistance Program Consultant for amounts for years prior to 2004.

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-09 \$96.40
 1-1-08 \$96.40
 1-1-07 \$93.50
 1-1-06 \$88.50
 1-1-05 \$78.20
 1-1-04 \$66.60

b. Medicare Part A premium amounts:

1-1-09 \$443.00
 1-1-08 \$423.00
 1-1-07 \$410.00
 1-1-06 \$393.00
 1-1-05 \$375.00
 1-1-04 \$343.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2004.

6. Classification

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

The cost-of-living increase(s) is not excluded when determining income eligibility in ANY other covered group. However, these individuals must be identified for possible future CNNMP protection as the SSI and AG income limits increase.

C. Entitlement & Enrollment

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

Eligible former SSI or AG recipients in this group are classified as categorically needy non-money payment (CNNMP). *The aid categories (ACs) are:*

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

D. Eligibility for Non-Protected Family Members

The amount of an SSA cost-of-living increase that must be excluded when determining eligibility for a former SSI recipient **cannot** be excluded when determining Medicaid eligibility of the individual's non-protected spouse and/or children living with the former SSI recipient.

The former SSI recipient is included in his/her non-protected spouse's unit if the non-protected spouse is aged, blind, or disabled.

The former SSI recipient is included as a member of the family unit when determining a child's eligibility in an F&C covered group. All of the protected recipient's income, including the cost-of-living increase(s), is counted.

M0320.104 PROTECTED WIDOWS OR WIDOWERS

A. Policy

Two groups of disabled widow(er)s who lost SSI eligibility because of receipt of or increase in Title II disabled widow(er)s' or Title II widow(er)s' benefits have their Medicaid categorically needy eligibility protected.

The first group consists of disabled widow(er)s who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under P.L. 98-21 in January 1984.

The second group consists of (1) disabled widow(er)s age 60 through 64 years and (2) disabled widow(er)s age 50 through 59 years who would be eligible for SSI except for early receipt of Social Security benefits.

B. July 1989 Protected Widow(er)s

42 CFR 435.137 - A "July 1989 protected widow(er)" is an individual who became entitled to SSA benefits when he/she had attained age 50 but not age 60 years, and

- who applied for Medicaid before July 1, 1989,

- was entitled to monthly OASDI benefits under Title II of the Social Security Act for December 1983,
- was entitled to and received widow's or widower's disability benefits under section 202(e) or 202(f) of the Social Security Act for January 1984,
- lost SSI and/or AG because of the January 1984 increase in disabled widow(er)'s benefits due to elimination of the reduction factor,
- has been continuously entitled to an SSA widow(er)'s disability benefit under section 202(e) or 202(f) of the Social Security Act since the first month that increase was received, and
- would be eligible for SSI or AG if the amount of the increase and any subsequent COLAs in the widow(er)'s SSA benefits were excluded.

**1. Nonfinancial
Eligibility**

Determine the widow(er)'s eligibility using the procedures below. The widow(er):

- a. meets the nonfinancial eligibility requirements in chapter M02;
- b. applied for Medicaid as a protected individual prior to July 1, 1989;
- c. was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act, for January 1984;
- d. became ineligible for SSI and/or AG payments because of the increase in the amount of his/her widow(er)'s benefit and:
 - the increase resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60,
 - he/she became ineligible for SSI and/or AG payments in the first month in which that increase was paid to him/her, and
 - a retroactive payment of that increase for prior months was not made in that month;
- e. has been continuously entitled to a widow(er)'s disability benefit under Section 202 (e) or (f) of the Social Security Act from the first month that the increase in his/her widow(er)'s benefit was received;
- f. would be eligible for SSI or AG if the amount of that increase, and any subsequent cost-of-living adjustments (COLAs) in the widow(er)'s benefits, were deducted from his/her income.

2. Financial Eligibility**a. Assistance Unit**

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Resource eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

c. Income Eligibility

- 1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's gross SSA benefit amount that was effective in December 1983 plus other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05. Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

- 2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's income must be within the current AG limit (home's rate plus personal care allowance). Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

- 3) If the individual is not income-eligible, Medicaid eligibility may exist in another covered group. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be determined eligible in a medically needy covered group.

**C. Protected Disabled
Widow(er)**

42 CFR § 435.138 specifies that categorically needy eligibility for Medicaid is protected for the group of disabled widow(er)s age 60 through 64 years who meet the criteria specified below. Under 42 USC § 1383c(d), Medicaid protected status was extended to the group of disabled widower(er)s age 50 through 59 years who meet the same criteria.

A protected disabled widow(er) is an individual who:

- is at least age 50 years (and has not attained age 65);
- is **not** eligible for Medicare Part A hospital insurance;
- becomes ineligible for SSI and/or AG because of mandatory application for and receipt of SSA Title II widow(er)'s disability benefits under section 202(e) or 202(f) of the Social Security Act (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f) of the Act).
- would be eligible for SSI or AG if the SSA widow(er)'s benefit were excluded from income.

**1. Nonfinancial
Eligibility**

The protected disabled widow(er) must:

- a. meet the nonfinancial eligibility requirements in chapter M02;
- b. have received SSI and/or AG for the month before the month in which he/she began receiving SSA Title II disabled widow(er)'s benefits or widow(er)'s benefits;
- c. be eligible for SSI or AG if the SSA widow(er)'s disability benefit were not counted as income.

**2. Financial
Eligibility**

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Financial eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

c. Income Eligibility

When determining a protected widow(er)'s eligibility in this covered group, the agency must deduct from the individual's income all of the Social Security benefits that made him or her ineligible for SSI.

- 1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's SSA benefit that made him/her ineligible for SSI must be excluded. Other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Exclude the protected individual's current SSA widow(er)'s benefit amount.

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

- 2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's countable income must be within the current AG limit (home's rate plus personal care allowance). Exclude the protected individual's current SSA widow(er)'s benefit amount.

Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected group.

- 3) If the individual is not income eligible, the individual must be evaluated for Medicaid eligibility in other covered groups. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount.

D. Entitlement & Enrollment

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

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). *The ACs are:*

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.105 QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (QSII)- 1619(B) STATUS

A. Introduction

42 CFR 435.121 - Under Section 1619(a) of the Social Security Act, a disabled individual who would otherwise lose SSI because of work and the demonstration of the ability to perform substantial gainful activity but continues to have a disabling impairment can continue to receive special SSI benefits if he continues to be financially eligible for SSI benefits based on income.

Section 1619(b) of the Act allows a disabled individual whose income is too high to retain financial eligibility for the special SSI benefit under Section 1619(a) and a blind individual who lost regular SSI payments to continue to receive Medicaid benefits under certain criteria specified in Section 1619(b).

The Social Security Administration (SSA) determines whether an individual who lost SSI because of earned income is eligible for 1619(b) status.

The local department of social services determines whether an individual who has a 1619(b) status continues to be eligible for Medicaid.

B. Identifying QSII Individuals

To identify a QSII individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen. If there is a code of A, B, or F, the individual has 1619(b) status.

Since eligibility for 1619(b) can change, check the SVES at each redetermination and when there is an indication that a change may have occurred.

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

2. Not QMB

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

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB.

E. Ineligible In This Covered Group

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

M0320.205 ABD HOSPICE

A. Policy

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

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. *Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.*

The 30-day requirement begins on the day the hospice care election statement is signed. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within 300% of SSI, eligibility in the Hospice covered group may be determined beginning with the month in which the hospice election was signed.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.

Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals. A patient pay *must be calculated for* individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

B. Nonfinancial Eligibility

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

1. Citizenship/alien status;
2. Virginia residency;
3. Social Security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Application for other benefits;
6. *Institutional status requirements*;
7. Application to the Health Insurance Premium Payment Program (HIPP);
8. Meets either the Aged, Blind, or Disabled definition in M0310 or is
9. **“deemed” to be disabled because of the terminal illness. Do not refer the individual to the DDS for a disability determination.**

C. Financial Eligibility**1. Asset Transfer**

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

2. Resources

The hospice services recipient is an assistance unit of 1 person. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements.

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

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group. He/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

a. Unmarried Individual

If the individual is unmarried or is married and has no community spouse, use the resource policy in chapter S11 and subchapter M1460.

b. Married Individuals

If the individual is married and has a community spouse, use the resource policy in chapter S11 and subchapter M1480.

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

C. Financial Eligibility

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

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

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.
4. **Income** The income limits are $\leq 80\%$ 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 is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

1. **Begin Date** If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.
2. **Retroactive Entitlement** ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged enrollee;
- 039 for a blind enrollee; or
- 049 for a disabled enrollee.

M0320.211 MEDICAID WORKS**A. Policy**

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals who are:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 80% of the FPL, (including SSI recipients) **and**
- who have countable resources less than or equal to \$2,000 for an individual and 3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future

to retain Medicaid coverage by cost-sharing through the payment of a premium as long as they remain employed and their earned income is less than or equal to 200% of the FPL. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. MEDICAID WORKS is Virginia's MBI program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

The 1619(b) work incentive status available to SSI recipients allows the individual to earn a significantly higher income than the MEDICAID WORKS income limit. However, 1619(b) uses the same resource limit as SSI, while the resource limit for MEDICAID WORKS is significantly higher. An individual with SSI who meets the criteria for Medicaid coverage as a Qualified Severely Impaired Individual (1619(b)) may choose to participate in MEDICAID WORKS because of the higher resource limit. An individual with SSI must not be discouraged from enrolling in MEDICAID WORKS.

C. Nonfinancial Eligibility

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- blind or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.
- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings accounts. The individual must provide documentation for the case

- record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with no other income but the wages earned while in MEDICAID WORKS. It cannot contain the individual's Social Security benefits.
- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on SPARK at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The agreement outlines the individual's responsibilities as an enrollee in the program.
- The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. Note: Monthly premiums are not being charged at this time.

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL. Resources and income from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, **the individual is treated as an assistance unit of one.** Spousal and parental resources and income are disregarded for ongoing enrollee eligibility.

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is \$2,000 for an individual and \$3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following resource policies apply:

- 1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2009 is \$30,478.

- 2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.** The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.
- 3) For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in i or ii above is \$2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination, the income limit is $\leq 80\%$ of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.201).

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:

- 1) The income limit for earned income is 200% of the FPL for one person (see M0810.002) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

- 2) The income limit for unearned income remains less than or equal to 80% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

**4. Income Exceeds
80% FPL at
Eligibility
Determination**

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 80% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

**E. Cost Sharing and
Premium Payment**

Cost sharing is required of all individuals enrolled in MEDICAID WORKS. Enrollees are responsible for copayments for services received (see M1850.100 B).

Premiums are assessed on a sliding scale based on the individual's income and are subject to change. Based on the sliding scale, some individuals may not owe a premium.

Note: premiums are not being charged at this time.

F. Good Cause

An individual may remain eligible for MEDICAID WORKS if one of the following good cause exceptions is met:

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months as long as any **required** premium payments continue to be made. The six-month period begins the first day of the month following the month in which the job loss occurred. The individual *should be asked to* provide documentation that he is unable to work from a medical or mental health practitioner or employer. *However, do not cancel the individual's eligibility under MEDICAID WORKS due to the lack of documentation if the individual indicates that he is still seeking employment.*
- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to a documented illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services.

G. Safety Net

Enrollees who are unable to sustain employment for longer than six months must be evaluated for continued coverage in all other Medicaid covered groups for which the individual meets the definition. Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility.

If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account are countable.

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.211 C.2.b.ii that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18).

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the MMIS is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

Complete the Medicaid Works fax cover sheet and fax it together with the following information to DMAS at 804-786-0973:

- a signed Medicaid Works Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
 - a pay stub showing current employment or
 - an employment letter with start date or
 - self-employment document(s).

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in MMIS:

New Application – Applicant Eligible as 80% FPL

1. For the month of application and any retroactive months in which the person is eligible in the 80% FPL covered group, enroll the individual in a closed period of coverage using aid category (AC) 039 (blind) or 049 (disabled), beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

Current Enrollee

1. Cancel current coverage using Cancel Code 042.

- 3) *the mother remains eligible for Medicaid or would be eligible if she were still pregnant (with the newborn)*

b. Living With Mother

A newborn child is considered living with its mother from the moment of birth until the child is

- entrusted or committed into foster care,
- institutionalized, or
- goes to live with someone other than the child's mother.

c. No Other Nonfinancial Eligibility Requirements

No other nonfinancial or financial eligibility requirements need to be met by the newborn child.

C. Financial Eligibility

1. Assistance Unit

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

If a pregnant woman also applies for other family unit members living with her who do not meet the pregnant woman, newborn child or child under age 19 years covered group requirements, separate financial eligibility calculations must be completed for the unit. One is the MI pregnant woman determination; the other is based on the other members' covered group(s).

2. Asset Transfer

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

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met by a pregnant woman. The income limits are 133% of the federal poverty limit and are found in subchapter M710, Appendix 6.

5. Income Changes After Eligibility Established

a. Pregnant Woman

Once eligibility is established as a pregnant woman, changes in income do not affect her eligibility as long as she meets the pregnant definition and the other nonfinancial Medicaid eligibility requirements. This also includes situations where eligibility is established in the retroactive period.

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning \$3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1. Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent

months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn. The newborn remains eligible so long as

- 1) the child resides in the home with the mother, and
 - a. the child and mother reside in Virginia.
 - b. the mother remains eligible for Medicaid or would be eligible if she were still pregnant (with the newborn)

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

6. Income Exceeds MI Limit

A pregnant woman whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, FAMIS MOMS. The income limit for FAMIS MOMS is 185% FPL. See chapter M22 to determine FAMIS MOMS eligibility.

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

D. Entitlement

Eligible MI pregnant women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group if pregnancy is verified as existing in the retroactive month(s).

The newborn's Medicaid coverage begins the date of the child's birth. A Medicaid application for the newborn child is not required until the month in which the child turns age 1.

Eligible medically indigent pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

After her eligibility is established as a medically indigent pregnant woman, the woman's Medicaid entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy. Medicaid coverage ends the last day of the month in which the 60th day occurs.

E. Enrollment

The AC (aid category) for MI pregnant women is "091." The AC for newborns born to women who were enrolled in Medicaid as categorically needy or MI is "093."

M0320.302 PLAN FIRST - FAMILY PLANNING SERVICES (FPS)**A. Policy**

Since October 2002, family planning services (FPS) have been available to eligible women up to 24 months after the receipt of a Medicaid-covered pregnancy related service.

Effective January 1, 2008, a new family planning services health program known as Plan First is available to **uninsured** men and women who have countable income within 133% FPL and have not had a sterilization procedure. The previous requirements for receipt of a Medicaid-paid pregnancy-related service by women and the time limitations have been eliminated from the Plan First requirements.

The Plan First Application Form must be submitted for eligibility to be determined in this covered group.

1. Plan First Applications

Uninsured men and women who have countable income within 133% FPL and have not had a sterilization procedure may be eligible for Plan First. **A Plan First application form is required** for initial eligibility and for each annual renewal. There is no automatic eligibility for Plan First other than the exception noted in A.1 above.

Retroactive coverage is NOT available in the Plan First covered group.

2. Determine Medicaid Eligibility First**a. Application Indicates Potential Full-benefit Medicaid Eligibility**

If the information contained in the Plan First application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home and has income within the LIFC income limit for the family unit size), the worker must determine whether eligibility for full benefit Medicaid coverage exists before the individual(s) can be determined eligible for Plan First.

b. Additional Information Needed For Full Benefit Medicaid

If additional information is needed to complete the eligibility determination for a full-benefit Medicaid covered group, the applicant must be given the opportunity to provide the additional information needed. If the additional information is not provided by the deadline, the worker will determine the applicant's eligibility for Plan First only.

c. Applicant Eligible for Plan First Only

If the applicant is not eligible for full benefit Medicaid but is eligible for Plan First, enrollment in Plan First must be made directly in the MMIS. ADAPT will not enroll eligible individuals in Plan First, even if the eligibility determination for full benefit Medicaid was done in ADAPT.

B. Nonfinancial Requirements**1. General Nonfinancial Requirements**

Men and women in this covered group 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.

Men and women who have been determined eligible for a full benefit Medicaid covered group are not eligible for this covered group.

DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

2. Creditable Health Insurance Coverage

Plan First men and women must **not** have creditable health insurance coverage. Creditable health insurance coverage includes:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term, limited coverage.

Creditable health insurance coverage does not include:

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

3. Sterilization Procedure

Individuals who have had a sterilization procedure (such as tubal ligation, hysterectomy, vasectomy) are **not** eligible for Plan First. Information regarding receipt of a sterilization procedure is collected on the Plan First application/renewal form.

If an individual enrolled in this covered group receives a sterilization procedure paid for by Medicaid, DMAS will take action to cancel the coverage and send the appropriate notice.

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

Use the assistance unit policy in chapter M05 to determine the FPS financial eligibility.

2. Resources

There is no resource limit.

3. Income

The income requirements in chapter M07 must be met for this covered group. The income limits are 133% FPL and are found in subchapter M710, Appendix 6.

4. Spenddown

Spenddown does not apply to this covered group.

D. Entitlement and Enrollment**1. Entitlement**

Eligibility in the Plan First covered group begins the first day of the month in which the Plan First application is filed, if all eligibility factors are met in the month. Retroactive coverage is NOT available in the Plan First covered group.

Coverage for Plan First can begin no earlier than January 1, 2008.

Completion of a Plan First application is required at each renewal.

2. Enrollment

The AC for Plan First enrollees is "080."

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

Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits.

Virginia has elected to cover children from age 6 to age 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

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

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

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

NOTE: a child who does not meet a Medicaid non-financial eligibility criterion AND who has excess income for Medicaid may be evaluated for FAMIS eligibility.

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

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

2. Asset Transfer

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

3. Resources

There is no resource limit.

1. Enrollment

The aid category (AC) for individuals in the CNNMP covered group of Individuals Under Age 21 is:

- 076 for a non-IV-E Foster Care child;
- 075 for a Department of Juvenile Justice child;
- 072 for a Non-IV-E Adoption Assistance child;
- 082 for a child under age 21 in an ICF or ICF-MR.

M0320.308 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

A. Policy

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

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

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid “Special Medical Needs” covered group.

The child’s eligibility in another covered group must be evaluated. If the child is under age 19, evaluate his eligibility in the FAMIS Plus covered group of MI Child Under Age 19 (see M0320.303). If the child is over age 19 but under age 21, the child may be eligible as a Non-IV-E Adoption Assistance child in the CNNMP Individuals Under Age 21 covered group. See section M0320.307.

B. Nonfinancial Eligibility Requirements

The child must

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

C. Financial Eligibility Requirements

- 1. Assistance Unit** The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the Special Medical Needs child's own income and resources are counted.
- 2. Asset Transfer** The asset transfer rules apply to Special Medical Needs children who are in long-term care. See subchapter M1450.
- 3. Resources** There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.
- 4. Income** Adoption assistance children in residential facilities do not have a different income limit. The F&C 100% standard of need income limit for one person in the child's locality is used to determine eligibility in the Special Medical Needs covered group.

For a Virginia Special Medical Needs adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

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

If the child's countable income exceeds the F&C 100% standard of need income limit, evaluate the child in the medically needy covered group of "special medical needs adoption assistance" in subchapter M0330.

D. Entitlement & Enrollment

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

The AC for individuals in the CNNMP covered group of Special Medical Needs Adoption Assistance children is "072."

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

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

3. Income

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

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

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

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

D. Entitlement & Enrollment

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

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

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the AC is "062."

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the AC is "060."

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals, redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

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

M0320.311 F&C HOSPICE

A. Policy

SMM 3580-3584 - The State Plan includes the covered group of children under age 21, pregnant women and parents or caretaker-relatives of dependent children who are terminally ill and who elect hospice benefits. The hospice covered group is for individuals who are not eligible in any other full-benefit Medicaid covered group.

In order to be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. *Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual renewal.*

The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

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

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

B. Nonfinancial Eligibility

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

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

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

M0520.000 FAMILIES & CHILDREN (F&C) FAMILY/BUDGET UNIT**M0520.001 OVERVIEW****A. Introduction**

This subchapter contains the policy and procedures for determining the assistance unit for an individual or family who meets a Families & Children (F&C) covered group. For F&C financial eligibility determination purposes, the assistance unit is called the “family/budget” unit. A household is divided into one or more family units.

The family unit’s financial eligibility is determined first. If the family unit has resources or income that cannot be verified or that exceeds the limit for the individual’s covered group, the family unit is divided into “budget” units if certain requirements are met.

B. Policy

Medicaid law prohibits the consideration of resources and income of any person other than a spouse or parent in the final Medicaid eligibility determination. Resources and income CANNOT be counted

- from a stepparent to a stepchild;
- from a sibling to a sibling;
- from a child to a parent;
- from a spouse or parent living apart from the individual, unless it is a voluntary or court-ordered or DCSE-ordered contribution (exception for individuals in long-term care);
- from an alien sponsor to the alien.

The family unit will include any child(ren) under age 21 living in the home for whom a unit member is legally responsible regardless of whether or not the child(ren) meet(s) a covered group, unless the child is specifically excluded.

1. Member In One Unit

An applicant/recipient can be a member of only one family unit or one budget unit at a time.

2. May Exclude A Child

The applicant can choose to exclude any child(ren) from the family unit for any reason. If the parent wants to exclude a child who has been listed on the application, the request for exclusion must be in writing. None of the excluded child’s needs are considered, and none of his income or resources are counted or deemed available to the unit. The advantages and disadvantages of the choice must be explained to the applicant or recipient.

3. Living Away From Home

A parent, or a child under age 21 who has not been emancipated, is considered living in the household for family unit composition purposes if the absence is temporary and the parent or child intends to return to the home when the purpose of the absence (such as employment, military service, education, rehabilitation, medical care, vacation, visit) is completed.

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

Children placed in psychiatric residential treatment facilities are considered absent from their home if their stay in the facility has been 30 days or more. A child who is placed in a psychiatric residential treatment facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of psychiatric residential placement occurs. Long-term care rules do not apply to these children.

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

C. Procedure

This section contains an overview of the F&C family unit and budget unit rules. The detailed policy and procedures are contained in the following sections:

- M0520.010 Definitions;
- M0520.100 Family Unit Rules;
- M0520.200 Budget Unit Rules;
- M0520.300 Deeming From Spouse;
- M0520.400 Deeming From Parent;
- M0520.500 Changes In Status;
- M0520.600 Pregnant Woman Budget Unit;
- M0520.700 Individual Under Age 21 Family Unit.

M0520.010 DEFINITIONS

A. Introduction

This section contains definitions of the terms used in the F&C family/budget unit policy and procedures.

B. Acknowledged Father

In Virginia, a man who is legally married to the mother of a child on the *child's* date of birth is considered to be the legal father of the child **UNLESS** another man has been determined by DCSE or a court to be the child's father. The man listed on the application form as the child's father is considered to be the child's acknowledged father when:

- the mother was not married to another man on the child's birth date, or
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father,

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

NOTE: Her declaration on the application of the child's father's name is sufficient unless there is evidence that contradicts the application. The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient. See M0310.123 for the definition of a parent.

BU #1 spouse deeming calculations:

a. Resource Deeming

\$ 800	husband's ½ of joint savings
<u>-1,000</u>	resource deeming standard
0	excess (no resources deemed to F&C spouse)

b. Income Deeming

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

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

M0520.400 DEEMING FROM PARENT

A. Policy

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

- the parent is an SSI recipient or has a 1619b status,
- the parent receives IV-E foster care or adoption assistance,
- the child is living away from home per M0520.001 B.3, or
- the child is a foster care child placed in the home for a trial visit of 6 months or less.

1. Deeming Standard

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

2. Single Parent or Parent and Stepparent with No Child in Common

When each child in the home has only one parent in the home and the parent is in a separate BU, subtract the whole deeming standard from the parent's countable resources and income.

Note: A stepparent is not a "parent" for deeming purposes.

**3. Both Parents
In Same BU-
Married With
Child in
Common**

a. No Stepchildren

When both parents (at least one child in common) are in the same BU and there are no stepchildren, subtract the whole deeming standard from the parents' resources and income.

b. Stepchildren

When both parents (at least one child in common) are in the same BU and they have at least one child in common in the home who is included in the family unit, subtract one-half of the deeming standard for the parents' BU from deemor parent's resources and income.

When both parents are in the same BU and all their children-in-common are excluded from the family unit, subtract the whole deeming standard for the parents' BU from the deemor parent's resources and income.

**4. Both Parents
In Different BUs**

When both parents (at least one child in common) are in separate BUs, subtract the whole deeming standard from the deemor parent's countable resources and income.

**B. Deeming
Resources (F&C
MN Only)**

To determine how much of the deemor parent's resources to deem to the child, use the following procedures:

**1. Determine
Countable
Resources**

Determine the value of countable resources owned solely by the parent and the value of countable resources owned jointly with the parent's spouse or another person, according to policy in chapter M06. All resources that are in the deemor parent's name only plus the deemor's share of jointly held resources are counted.

**2. Subtract
Resource
Deeming
Standard**

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole resource deeming standard of \$1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).

Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

b. Both Parents In Same BU With Child in Common

1) Subtract the whole deeming standard of \$1,000 from the parents' countable resources when there are children in common and no stepchildren in the home.

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

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

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

B. Procedure

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

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

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

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

1. Child Living With Parents

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

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

- the child has his/her own resources (F&C MN only);
- the child has his/her own income;
- the child’s stepparent is in the family unit;
- the child’s parent with whom he/she lives is a minor (under age 21) and they live with the minor parent’s parent(s);

- the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

2. Child Placed In Own Home For Trial Visit

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

The trial visit is no longer than 6 months for this section's purposes. A child will continue to be a single person BU during a trial visit and only the child's income and resources will be counted in determining the child's Medicaid eligibility.

3. Foster Care Payment Is Excluded

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

B. Examples

1. Trial Visit

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

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

2. Home Placement, Not Trial Visit

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

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

A. Policy

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

1. Child Living With Parent(s)

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

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M0530.000 ABD ASSISTANCE UNIT

M0530.001 OVERVIEW

A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for a non institutionalized individual who meets an aged, blind or disabled (ABD) covered group. Do not use this subchapter for an institutionalized individual; use subchapter M1460 to determine an institutionalized individual's financial eligibility.

The number of persons in the assistance unit and the individual's covered group determine which resource and income limits apply. The deeming policy and procedures in this subchapter explain how to determine how much of a legally responsible relative's resources and income is deemed to the ABD individual.

Appendix 1 to this chapter lists the deeming allocations used when deeming income of a legally responsible relative.

B. Assistance Unit Composition

When determining composition of the ABD assistance unit, identify the individual who applies for Medicaid, who meets the aged, blind or disabled definition in M0310 and who meets an ABD covered group's requirements.

1. Responsible Relatives

a. Spouse

The unit must include the individual's spouse with whom the individual lives when the spouse applies for Medicaid and meets the aged, blind or disabled definition in M0310, regardless of whether the spouse receives an SSI or IV-E foster care/adoption subsidy payment.

b. Parent of Blind/Disabled Child Under Age 21

The parent(s) with whom the blind or disabled child under age 21 lives is legally responsible to support the child. However, the parent is not included in the child's assistance unit. The parent's resources and income are deemed available to the child.

2. SSI Recipients

The policy in this subchapter applies when determining the **resource** eligibility of individual SSI recipients or of couples when both spouses receive SSI and one or both owns an interest in real property contiguous to the home or undivided interest in heir property, or a former residence.

However, this subchapter does **not** apply to the **income eligibility** determination of an SSI recipient because an SSI recipient meets the Medicaid income eligibility requirements just by the fact that he/she receives an SSI payment.

- 3. Living With Family and Children** If the ABD individual lives with his/her spouse and/or dependent child(ren) who request Medicaid in a families and children covered group, the policy in this subchapter applies only to the ABD individual. Use the assistance unit policy in M0520 and the financial requirements in chapters M06 and M07 for the family members who meet an F&C covered group.
- 4. Living Arrangement** An ABD individual's, couple's or child's living arrangement on the first day of the month is used to determine the individual's status for the entire month. If they are living together (or child is living with parent) on the first of the month, they are living together for the entire month except when separation due to institutionalization occurs within the month. If they are living apart on the first of the month, they are considered separated for the entire month.
- When an individual is admitted to an Adult Care residence (ACR) or other residential facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first of the month following the admission month.
- 5. Institutionalization** When an individual is institutionalized in a medical facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first day of the month in which he is admitted to a nursing facility or to Medicaid-approved community-based care waiver services. He is considered separated as of the first of the month during which he has been hospitalized in an acute care or rehabilitation hospital for 30 consecutive days.
- If an individual is institutionalized, do not use this subchapter. Use the policy and procedures in chapter M14 to determine an institutionalized individual's eligibility.
- 6. Deeming From Married Parent** When determining how much of the child's parent's income is deemed available to the child's unit, any income of the parent's spouse who is not the child's parent is not counted.
- C. Pregnant Blind or Disabled Woman** If the blind or disabled individual also meets the pregnant woman definition, first determine the woman's eligibility in the MI Pregnant Woman covered group using the F&C assistance unit and financial eligibility rules. If she is not eligible as an MI pregnant woman, then determine her eligibility as an ABD individual.
- D. Spenddown Expenses** If an ABD assistance unit is ineligible because of excess income, the assistance unit's member(s)'s medical expenses will count toward the spenddown. If an individual in the unit is legally liable for another person in the household who is not in the assistance unit, the other person's medical bills can count toward the unit's spenddown. If the ABD individual's spouse's or parent's income is deemed to the individual, the spouse's or parent's medical expenses are also deducted from the ABD individual's spenddown.
- A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses

M0530.100 UNMARRIED INDIVIDUAL (AGE 21 OR OLDER)

- A. Policy** An unmarried ABD individual's assistance unit consists of one person--the individual. The individual's child(ren) living with him or her are NOT included in the ABD individual's assistance unit, nor is any of the individual's resources or income allocated for the child(ren) when determining countable resources and countable income.
- B. Assistance Unit** Resources Determination - unit of one.
Income Determination - unit of one.

M0530.200 MARRIED INDIVIDUAL LIVING WITH SPOUSE

- A. Introduction** A married individual living with his/her spouse is always an ABD couple assistance unit (2 persons) for the **resource** eligibility determination. For the **income** eligibility determination, a married individual living with his/her spouse is an ABD couple assistance unit (2 persons) when the NABD spouse has deemable income, or an assistance unit of 1 person when the NABD spouse has no deemable income.
- An aged, blind, or disabled individual or couple found guilty of Medicaid fraud by a court is ineligible for Medicaid benefits for a period of twelve months from conviction. If only one member of an aged, blind, or disabled couple is found guilty, the innocent spouse's eligibility is not affected. The assistance unit remains the same. The guilty spouse is ineligible for twelve months (*see M1700.200*).
- B. Procedure** For an ABD couple, see M0530.201.
For an ABD individual with an NABD spouse, see M0530.202 and 203 below.

M0530.201 ABD COUPLE ASSISTANCE UNIT

- A. Policy** This section contains the policy and procedures for determining an ABD couple's assistance unit.
- When a married couple is living together and each individual in the couple meets the Aged, Blind or Disabled definition in M0310, AND each

Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

2009: $\$1,011 - \$674 = \$337$

2008: $\$956 - \$637 = \$319$

Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = $\$674$ for 2009
 $\$637$ for 2008

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = $\$1,011$ for 2009
 $\$956$ for 2008

Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

2009: $\$1,011 - \$674 = \$337$

2008: $\$956 - \$637 = \$319$

M0710.000 GENERAL-- F&C INCOME RULES

M0710.001 OVERVIEW

- A. Introduction** Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. This section addresses how to determine an individual's income eligibility.
- B. Use of Family Units/Budget Units** Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU) rules permit, form BUs.
- Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.
- See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.
- C. Individual Income Eligibility** An individual's income eligibility is based on the total countable income available to his/her FU/BU.
- Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.
- D. Policy Principles**
- 1. Income** Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.
- Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.
- 2. Verification** All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of *income to be counted*.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

- 3. Converted Income**

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

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

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used *to determine eligibility for that month* if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.
- 5. MI, CN, CNNMP Monthly Income Determination Period**

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

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

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

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

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

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

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

When a BU has countable income totaling more than the allowable CN, CNNMP, or MI income limit for the evaluation period, eligibility as CN, CNNMP, or MI does not exist. Evaluate the BU's as Medically Needy eligibility if one or more of the BU members meets a MN covered group. If no members of the BU meet a MN covered group, the BU is not eligible for Medicaid because of excess income.

12. Excluded Income

State and federal policy require that certain types of income or portions of income be excluded (not counted) when determining income eligibility. See:

- Earned Income Exclusions, M0720.500
- Unearned Exclusions, M0730.099

M0710.002 INCOME LIMITS

A. Introduction

The individual's Medicaid classification determines which income limit to use to determine eligibility.

B. Income Limits

1. CN and CNNMP

Refer to M0710, Appendix 1 for the LIFC 185% of the Standard of Need Chart, M0710, Appendix 2 for the grouping of localities, and M0710, Appendix 3 for the F&C 90% and 100% Income Limit Charts.

2. MN

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

3. MI

Refer to M0710, Appendix 6 for the MI income limits.

M0710.003 NET COUNTABLE INCOME

A. Policy Principle

Income is

- cash, or
- its equivalent unless specifically listed in M0715 as not being income.

B. Available Income

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used *to determine eligibility for that month* if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

C. Net Countable Income

Net countable income is all money, both earned and unearned, which is available to the members of the FU/BU, after portions specifically excluded and all amounts that are not income are subtracted.

Sometimes, countable income includes more or less money than is actually received. For example, gross earnings before deductions are counted when determining eligibility for FAMIS; no deductions or exclusions are subtracted from the gross earnings.

M0710.004 INCOME EXCLUSIONS

- A. Introduction** Medicaid eligibility is based on countable income. See M0710.003 for the definition of countable income. In determining countable income, apply any income exclusions. Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted.
- B. Definition** Excluded income is an amount which is income but does not count in determining eligibility.
- C. Policy Principles** Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. Section 402(a) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.
- D. References**
- Earned income exclusions, M0720.500
 - Unearned income exclusions, M0730.099

M0710.010 RELATIONSHIP OF INCOME TO RESOURCES

- A. Policy** In general, anything received in a month from any source is income to an individual, subject to the definition of income in M0710.003.
- Anything the individual owns in the month under consideration is subject to the resource counting rules.
- An item received in the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules.
- B. References**
- Definition of Resources, M0610.100
 - Conversion or sale of a resource, M0715.200
 - Casualty property loss payments, M0630.650
 - Lump sums, M0730.800

M0710.015 TYPES OF INCOME

- A. Policy Principle** Income is either earned or unearned, and different rules apply to each.
- B. Types of Income**
- 1. Earned Income** Earned income consists of the following types of payments:
 - wages;
 - salaries, and/or commissions;
 - profits from self employment; or
 - severance pay.

MEDICALLY INDIGENT CHILD UNDER AGE 19 (FAMIS PLUS) INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-23-09 ALL LOCALITIES		
# of persons in Family/Budget Unit	100% FPL Monthly Limit	133% FPL Monthly Limit
1	<i>\$903</i>	<i>\$1,201</i>
2	<i>1,215</i>	<i>1,615</i>
3	<i>1,526</i>	<i>2,030</i>
4	<i>1,838</i>	<i>2,444</i>
5	<i>2,150</i>	<i>2,859</i>
6	<i>2,461</i>	<i>3,273</i>
7	<i>2,773</i>	<i>3,688</i>
8	<i>3,085</i>	<i>4,102</i>
Each additional person add	<i>312</i>	<i>415</i>

AC 091 - MI Child under age 6 with income less than or equal to 100% FPL

AC 092 - MI Child age 6 to 19 with income less than or equal to 100% FPL

AC 090 - MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL

AC 092 - **Insured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL

AC 094 - **Uninsured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL

MEDICALLY INDIGENT PREGNANT WOMAN INCOME LIMITS 133% FPL EFFECTIVE 1-23-09 ALL LOCALITIES	
# of persons in Family/Budget Unit	133% FPL Monthly Limit
2	1,615
3	2,030
4	2,444
5	2,859
6	3,273
7	3,688
8	4,102
Each additional person add	415

AC 091 - Pregnant Woman with income less than or equal to 133% FPL

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-23-09 ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	<i>\$1,670</i>
2	<i>2,247</i>
3	<i>2,823</i>
4	<i>3,400</i>
5	<i>3,976</i>
6	<i>4,553</i>
7	<i>5,130</i>
8	<i>5,706</i>
Each additional person add	<i>577</i>

AC 081 – LIFC one parent or caretaker in home

AC 083 – LIFC both parents in home

M0715.370 SHELTER CONTRIBUTED

A. Policy Shelter that is contributed is not income.

*This includes payments for shelter made to a third party (such as a rental agency) in lieu of or in addition to child support, whether the payments made in lieu of support are based on a court order, establishment or pending establishment of a child support order, or a mutual voluntary agreement between the Medicaid applicant/enrollee. The payments made to a third party are **not** counted as income.*

B. Reference Child/Spousal Support, M0730.400

M0715.400 BILLS PAID BY A THIRD PARTY

A. Policy Bills paid by a third party directly to a supplier are not income.

EXAMPLE: A church pays the electric company for Mrs. Brown's electric bill. This is a bill paid by a third party and is not income to Mrs. Brown.

B. Exceptions Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a day care provider or telephone company in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/recipient and the responsible person, are NOT counted as unearned income to the family/budget unit.

Third party payments made by an absent spouse in lieu of spousal support are treated as contributions in kind and are not counted as income.

C. Reference Child/Spousal Support, M0730.400

B. Definitions

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

C. List of Benefits

The following are examples of benefits:

Social Security Benefits
VA Payments
Worker's Compensation
Railroad Retirement
Black Lung Benefits
Civil Service Payments
Military Pensions
VIEW Transitional Payments

D. Procedure

Verify entitlement amount and amount being received by documents in the applicant/enrollee's possession, such as an award letter or benefit payment check, or by contact with the entitlement source.

M0730.200 UNEMPLOYMENT COMPENSATION

A. Policy

Unemployment Compensation received by an individual is counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedures

Count Unemployment Compensation as unearned income for all covered groups, but do not count it in the 185% income screening for LIFC.

Exclude Unemployment Compensation in the 185% income screening for LIFC. Count Unemployment Compensation in the 90% income screening.

M0730.210 TRADE ADJUSTMENT ASSISTANCE ACT INCOME

A. Policy

The Trade Adjustment Assistance Act is administered by the Virginia Employment Commission. The Act allows qualified unemployed individuals to receive additional weeks of Unemployment Compensation (UC). UC benefits are counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedure

See M0730.200, above, for procedures to use in counting UC benefits.

M0730.400 CHILD/SPOUSAL SUPPORT**A. Policy**

Support received by an individual, whether it comes directly from the provider or is redirected to the individual by DCSE, is unearned income. The support received by the individual is subject to the \$50 Support Exclusion.

B. TANF Recipients**1. Distribution of Support**

As a condition of eligibility for Temporary Assistance to Needy Families (TANF), an individual is required to assign to the State any rights to support from an absent parent of a child receiving TANF.

The State, through the Division of Child Support Enforcement (DCSE), sends the first \$100 of support collected in a month on behalf of the TANF assistance unit to that unit. (If the total support collected is less than \$100, the entire amount is sent to the unit.) Any remaining amount of support is kept by the State as reimbursement of TANF payments made to the family. If DCSE collects more support than the State is entitled to keep as reimbursement for TANF paid, it will forward the excess *amount* to the TANF assistance unit. That excess amount is counted as unearned income.

2. \$100 Pass Through

Child support collected by DCSE and paid to a TANF assistance unit as a \$100 (or less) pass-through of child support, is income to the Medicaid family/budget unit *when the pass-through check exceeds \$50.00 per month. The amount of the monthly pass-through check that exceeds \$50.00 is counted for Medicaid eligibility.*

3. Amount in Excess of the Pass-Through

Child support collected by DCSE and forwarded to a TANF family because the support exceeds the amount which the State is entitled to keep as reimbursement for TANF is a payment of child support and is counted as unearned income.

4. Retained by State

Child support collected by a State and retained as reimbursement for TANF payments is not income to a Medicaid applicant/enrollee.

5. After TANF Stops

If the Medicaid enrollee has been removed from the TANF unit and is no longer included in the money payment, the assignment of rights to support for that individual is no longer valid (except with respect to any unpaid support obligation that has accrued under the assignment). From that point forward, the Medicaid enrollee is entitled to receive from the State his or her share of any support collected on his behalf. Any support received is unearned income in the month received.

C. Individual Not Receiving TANF**1. Direct Child/Spousal Support**

Support collected by DCSE and paid to the Medicaid family/budget unit is unearned income in the form of child support to the family/budget unit. Support paid directly to the Medicaid family/budget unit by an absent parent or spouse is unearned income in the form of child/spousal support to the family/budget unit.

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles

- 1. Who is Eligible** An individual is eligible for Medicaid if the person:
- meets a covered group; and
 - meets the nonfinancial requirements; and
 - meets the covered group's resource limits; and
 - meets the covered group's income limits.
- 2. General Income Rules**
- Count income on a monthly basis.
 - Not all income counts in determining eligibility.
 - If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits The Medicaid covered group determines which income limit to use to determine eligibility.

1. Categorically Needy Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy covered group.

2. Categorically Needy Non-Money Payment-Protected Cases Only

Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2009 Monthly Amount	2008 Monthly Amount
1	\$674	\$637
2	1,011	956
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2009 Monthly Amount	2008 Monthly Amount
1	\$449.33	\$424.67
2	674.00	637.33

**3. Categorically
Needy-Non
Money Payment
(CNNMP) –
300% of SSI**

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as “what is not income” in S0815.000.

Categorically Needy-Non Money Payment 300% of SSI		
Family Size Unit	2009 Monthly Amount	2008 Monthly Amount
1	\$2,022	\$1911

**4. Medically
Needy**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,592.39	\$ 265.39
2	2,027.57	337.92
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,837.38	\$ 306.23
2	2,262.85	377.14
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,389.59	\$ 398.26
2	2,880.04	480.00

**5. ABD Medically
Indigent**

**For:
ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security (SS) and
QDWI, effective
1/23/09;
ABD 80% FPL,
QMB, SLMB, &
QI with SS,
effective 3/01/09;
MEDICAID
WORKS,
effective 1/23/09**

ABD 80% FPL	Annual	Monthly
1	\$8,664	\$722
2	11,656	972
QMB 100% FPL	Annual	Monthly
1	\$10,830	\$903
2	14,570	1,215
SLMB 120% of FPL	Annual	Monthly
1	\$12,996	\$1,083
2	17,484	1,457
QI 135% FPL	Annual	Monthly
1	\$14,621	\$1,219
2	19,670	1,640
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$21,660	\$1,805
2	29,140	2,429

C. Procedure

1. **Verification**
 - a. Verify these payments by examining documents in the individual's possession which reflect:
 - the amount of the payment,
 - the date(s) received, and
 - the frequency of payment, if appropriate.
 - b. If the individual has no such evidence in his possession, contact the source of the payment.
 - c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.
2. **Assumption**

Assume that any honoraria received is **in consideration of services rendered**, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honoraria is for something other than services rendered (e.g., travel expenses or lodging).
3. **Expenses of Obtaining Income**

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)
4. **Documentation**

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

- D. References
- Royalties as unearned income, S0830.510.
 - To determine deductible IRWE/BWE, see S0820.535 - .565.

EARNED INCOME EXCLUSIONS

S0820.500 GENERAL

A. Policy

1. **General**

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.
2. **Other Federal Laws**

First, income is excluded as authorized by other Federal laws.

3. Other Earned Income

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

- a. Federal earned income tax credit payments
- b. Up to \$10 of earned income in a month if it is infrequent or irregular
- c. For 2008, up to \$1,550 per month, but not more than \$6,240 in a calendar year, of the earned income of a blind or disabled student child.

For 2009, up to \$1,640 per month, but not more than \$6,600 in a calendar year, of the earned income of a blind or disabled student child.
- d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month
- e. \$65 of earned income in a month
- f. Earned income of disabled individuals used to pay impairment-related work expenses
- g. One-half of remaining earned income in a month
- h. Earned income of blind individuals used to meet work expenses
- i. Any earned income used to fulfill an approved plan to achieve self-support

4. Unused Exclusion

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

5. Couples

The \$20 general and \$65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 \$20 general exclusion
- S0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

- 1. General** For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

For Months	Up to per month	But not more than in a calendar year
In calendar year 2008	\$1,550	\$6,240
In calendar year 2009	\$1,640	\$6,600

- 2. Qualifying for the Exclusion** The individual must be:
- a child under age 22; and
 - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility** Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases** The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

- 1. Application of the Exclusion** Apply the exclusion:
- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
 - only to a student child's own income.
- 2. School Attendance and Earnings** Develop the following factors and record them:
- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
 - the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be \$65 or less per month.

C. References

- Grants, scholarships and fellowships, S0830.455.
- Educational assistance with Federal funds involved, S0830.460.

D. Example

*(Using April
2002 Figures)*

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns \$1,600 a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns \$800 a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August

\$1600.00	gross earnings
<u>- 1320.00</u>	student child exclusion
\$ 280.00	
<u>- 20.00</u>	general income exclusion
\$ 260.00	
<u>- 65.00</u>	earned income exclusion
\$ 195.00	
<u>- 97.50</u>	one-half remainder
\$ 97.50	countable income

Jim has used up \$3,960 of his \$5,340 yearly student child earned income exclusion (\$1,320 in each of the three months).

September

\$800.00	gross earnings
<u>- 800.00</u>	student child exclusion
0	countable income

Jim has now used up \$4,760 of his \$5,340 yearly student child earned income exclusion.

October

\$800.00	gross earnings
<u>- 580.00</u>	student child exclusion <i>remaining (\$5,340-\$4,760=\$580)</i>
\$220.00	
<u>- 20.00</u>	general income exclusion
\$200.00	
<u>- 65.00</u>	earned income exclusion
\$135.00	
<u>- 67.50</u>	one-half remainder
\$ 67.50	countable income

Jim has exhausted his entire \$5,340 yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

3. **IRWE Used for Other Daily Activities** Any expense may meet the criteria for an IRWE even if it also is used for daily activities other than work.
4. **Application of Exclusion**
- a. The IRWE exclusion only applies to earned income. IRWE in excess of the earned income an individual receives during the month are never deducted from unearned income. (See S0820.560 for allocating expenses.)
 - b. The IRWE exclusion is applied to earned income in the sequence below:
 - immediately **after** deducting:
 - any portion of the general income exclusion which has not been deducted from unearned income; **and**
 - the \$65 earned income exclusion; **and**
 - immediately **before** deducting one-half of the remaining earned income.

M0820.545 WORK EXPENSES – INTERACTION WITH OTHER POLICIES

- A. Introduction** This section discusses the interaction of other policies with work expenses.
- B. Policy-Items Deductible Under Other Provision**
- 1. Self-Employment** If the cost of an item has been deducted in figuring net earnings from self-employment (NESE) as described in S0820.200, it cannot be deducted as a work expense.
 - 2. Community Residence** When an individual resides in a community residence, the individual's payments for work related attendant care can be used to reduce countable earnings.
 - 3. PASS**
 - a. A PASS permits an individual to set aside income and resources for a limited period of time in order to reach a work goal. (For a more comprehensive discussion on PASS, see M0810.430)
 - b. Income used to pay for a particular work-related item may not be excluded from countable income under the PASS and the BWE or IRWE provisions simultaneously.
 - c. Unlike BWE or IRWE, a PASS may be used to reduce countable unearned income and resources.
- C. Policy – Deeming** In determining how much of an ineligible spouse's or parent's income is subject to deeming, earnings which are used to meet work expenses are not counted, if the ineligible spouse or parent is blind or disabled. Accept the individual's allegation of blindness or disability. Work expenses should be documented and verified according to S0820.550.

retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

C. Procedure

1. General

Obtain evidence from the individual's own records, if available. If the individual does not have sufficient evidence, contact the appropriate Military Finance Center as shown in 2. below.

2. Contacting the Military Finance Centers

- a. If information must be requested from a Military Finance Center, send a request with the individual's authorization to release the information.
- b. Include the following information on the request form:
 - The service member's given name, middle initial and surname;
 - The service member's service identification number (if available);
 - The service member's SSN;
 - The annuitant's or allottee's name; and
 - The annuitant's or allottee's SSN.
- c. **Specify the period** for which payment information is needed and identify the pay plan (e.g., RSFPP, SBP).
- d. The following is a listing of the mailing address for each Military Finance Center.

Military Service Branch	Military Finance Center Mailing Addresses
ARMY	USAFAC Director, Retired Operations Indianapolis, IN 46249 ATTN: Management Support Office
NAVY	Defense Finance Accounting Service Code 305 Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199
AIR FORCE	DFAF/DE/CIDM Denver, CO 80279-5000
MARINE CORPS	Marine Corps Finance Center 1500 E. Bannister Street Kansas City, MO 64197

D. References

- Income based on need, S0830.170

M1110.515 OWNERSHIP IN FEE SIMPLE OR LESS THAN FEE SIMPLE

A. Definitions

- 1. Fee Simple**

Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power of disposition of the property during his or her lifetime. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.
- 2. Less than Fee Simple Ownership**
 - a. Life Estate**

A life estate confers upon one or more persons (grantees) certain rights in a property for his/her/their lifetimes or the life of some other person. A life estate is a form of legal ownership and usually created through a deed or will or by operation of law. See B. below.
 - b. Equitable Ownership**

An equitable ownership interest is a form of ownership that exists without legal title to property. It can exist despite another party's having legal title (or no one's having it). See C. below.

B. Description-- Life Estate

- 1. Rights of Life Estate Owner**
 - a. What Owner Can Do**

Unless the instrument (will or deed) establishing the life estate places restrictions on the rights of the life estate owner, the owner has the right to possess, use, and obtain profits from the property and to sell his or her life estate interest.

The value of a life estate created prior to 8/28/08 is not counted as a resource. The value of a life estate created on or after 8/28/08 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S11. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created. See M1140.110 for additional information.
 - b. What Owner Cannot Do**

A life estate owner owns the physical property only for the duration of the life estate. The owner generally can sell only his or her interest; i.e., the life estate. The owner cannot take any action concerning the interest of the remainderman.
- 2. Remainder Interest**
 - a. Future Interest in Physical Property**

A life estate instrument often conveys property to one person for life (life estate owner) and to one or more others (remaindermen) upon the expiration of the life estate. A remainderman has an ownership interest in the physical property but without the right to possess and use the property until termination of the life estate.

b. Sale of Remainder Interest

Unless restricted by the instrument establishing the remainder interest, the remainderman is generally free to sell his/her interest in the physical property even before the life estate interest expires. In such cases, the market value of the remainder interest is likely to be reduced since such a sale is subject to the life estate interest.

3. Example

Mr. Heath, now deceased, had willed to his daughter a life estate in property which he had owned in fee simple. The will also designated Mr. Heath's two sons as remaindermen. Ms. Heath has the right to live on the property until her death at which time, under the terms of her father's will, the property will pass to her brothers as joint tenants.

C. Policy--Equitable Ownership Interest

Basically, existence of an equitable ownership interest is determined by a court of equity.

1. Unprobated Estate

For Medicaid purposes, an individual may have an equitable ownership interest in an unprobated estate if he or she:

- is an heir or relative of the deceased;
- receives income from the property; or
- has acquired rights in the property due to the death of the deceased in accordance with State intestacy laws.

M1120.215 contains instructions on how to determine whether an interest in an unprobated estate is a resource.

2. Trust

A trust is a right of property established by a trustor or grantor. One party (trustee) holds legal title to trust property which he or she manages for the benefit of another (beneficiary). The beneficiary does not have legal title but does have an equitable ownership interest.

M1120.200 contains instructions concerning resources treatment of trusts in the Medicaid program.

M1120.201 contain instructions for the resources treatment of trust established on or after August 11, 1993.

3. Equitable Home Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a medical assistance program consultant for an opinion from legal counsel.

M1130.140 REAL PROPERTY FOLLOWING REASONABLE BUT UNSUCCESSFUL EFFORTS TO SELL

A. Policy Principles

1. Exclusion

Real property, *including a life estate in real property*, that an individual has made reasonable but unsuccessful efforts to sell, will continue to be excluded for as long as:

- the individual continues to make reasonable efforts to sell it; and
- including the property as a countable resource would result in a determination of excess resources.

This exclusion is effective the first of the month in which the most recent application was filed or up to three months prior if retroactive coverage is required.

B. Operating Procedure

The "current market" value (CMV) of real property located in Virginia is the tax assessed value of the property. For property located outside of Virginia the CMV is determined by applying the tax assessed value of the property to the local assessment rate, if the rate is not 100%.

1. Initial Effort Established

The following criteria define reasonable efforts to sell. The listing price must not exceed 100% of CMV.

A reasonable effort to sell is considered to have been made:

- a. As of the date the property becomes subject to a realtor's listing agreement if, it is listed at current market value, **AND** the listing realtor verifies that it is unlikely to sell within 90 days of listing given particular circumstances involved; for example
 - owner's fractional interest;
 - zoning restrictions;
 - poor topography;
 - absence of road frontage or access;
 - absence of improvements;
 - clouds on title;
 - right of way or easement;
 - local market conditions; or
- b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsalable at CMV (other reasons are not sufficient); or

- c. *When the* applicant has personally advertised his property at or below CMV for 90 days by use of a "Sale by Owner" sign located on the property and by other reasonable efforts, such as newspaper advertisements, reasonable inquiries with all adjoining land-owners, or other potential interested purchasers.
- d. For property owned by an individual who is incompetent if no general power of attorney exists:

When court action is initiated for appointment of a guardian or *conservator* to secure the court's approval to dispose of the property, an initial effort to sell shall be deemed to have been made beginning the date the hearing for appointment of a guardian is placed on the court docket and continuing until the court authorizes sale of the property or six months, whichever is less.

Any period of time in excess of six months to secure appointment of a guardian and authorization to sell by the court is not deemed reasonable and the property loses this exemption. Upon authorization, and only upon authorization, the guardian must make a continuing reasonable effort to sell the property as described in paragraph B.3.

- e. For property which is an interest in an undivided estate and for jointly owned property when a co-owner refuses to sell:

An initial reasonable effort to sell shall have been made when all other co-owners have refused to purchase the applicant's or recipient's share, and at least one of the other co-owners has refused to agree to sell the property. After an initial effort to sell has been made, the individual must immediately make a continuing effort to sell in accordance with 3.d. below.

2. **Retroactive Exclusion**

There will be applications received with property already listed for sale. Inform the applicant of Reasonable Efforts to Sell policy.

Reasonable efforts to sell may have been made if the property was listed at more than 100% CMV. The following criteria will be applicable to property already listed for sale when the application is received. To receive the Reasonable Efforts to Sell exclusion for the month of application and the retroactive period when property has already been listed, the following criteria must be met:

- If the property was listed **at** or **below** 150% of CMV, the Reasonable Efforts to Sell exclusion will be granted for the month of application and the retroactive time period when the requirements in B.1., except for the listing price, are met.
- If property was listed **higher** than 150% of CMV, reasonable effort to sell *cannot be established in the retroactive period.*

The above is a screening trigger to determine if property may be excluded.

M1140.110 OTHER PROPERTY RIGHTS

A. Introduction

1. **Mineral Rights** Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.
2. **Timber Rights** Timber rights permit one party to cut and remove free standing trees from the property of another property.
3. **Easements** An easement gives one party the right to use the land of another party for a special purpose.
4. **Leaseholds** A leasehold gives one party control over certain property of another party for a specified period. In some States, a "lease for life" can create a life estate under common law. *See M1140.110A.6 for life estates.*
5. **Water Rights** Water rights usually confer upon the owner for riverfront or storefront property the right to access and use the adjacent water.
6. **Life Estates**
 - a. **General**

A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage.

The owner of a life estate can sell the life estate but does not have title to the property and thus normally cannot sell it or pass it on as an inheritance.

b. Life Estate Created Prior to 8/28/08

The value of a life estate created prior to 8/28/08 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

c. Life Estate Created On or After 8/28/08

The value of a life estate created on or after 8/28/08 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S11. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

The value of a life estate in real property on which the individual resides and considers to be his home is excluded. If the individual leaves the property but retains a life estate, and the property is not occupied by a spouse or dependent child, the value of the life estate becomes a countable resource unless it is excluded under one of the real property exclusions contained in Chapter S11.
7. **Remainder Interests** When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property.

B. Development and Documentation

1. General

Treat the items in A. above as real property and develop ownership and value per S1140.100. See 4. below for additional instructions regarding life estates and remainder interests.

2. Mineral Rights

a. Ownership of Land and Mineral Rights

If the individual owns the land to which the mineral rights pertain, the CMV of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

b. Ownership of Mineral Rights Only

If the individual does not own the land to which the mineral rights pertain, obtain a CMV estimate from a knowledgeable source. Such sources include, in addition to those listed in S1140.100 D.2.c.:

- the Bureau of Land Management;
- the U.S. Geological Survey;
- any mining company that holds leases.

3. Lease for Life

Refer any "lease for life" agreement and related information to the regional coordinator for a determination of whether it creates a life estate under State law.

4. Value of Life Estate or Remainder Interest

a. General

The value of a life estate created on or after 8/28/08 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S11.

b. Calculate Value of Life Estate

To determine the countable value of a life estate, use the table in S1140.120. Multiply the CMV of the property by the life estate or remainder interest decimal that corresponds to the individual's age. Record the result.

If there is more than one life estate, divide the equity value of the real property by the number of people having a life estate interest. Multiply the prorated equity value of the property by the life estate or remainder interest decimal that corresponds to the individual's age. Record the result.

c. Life Estate Affects Property Value

Any countable equity value of real property would be affected if it is:

- subject to someone else having life estate interest, or
- the applicant/recipient transfers their real property retaining a life estate interest, thus affecting the value for evaluation of transfer of assets.

See S1140.120, Life Estate and Remainder Interest Tables to determine CMV of real property owned by an applicant or recipient.

If the institution still refuses to provide the information, inform the individual and ask him or her to try to get the information from the institution.

**C. Development and Documentation--
Posteligibility Only**

If you discover a previously undeveloped checking or savings account after eligibility has been established, develop account balances and interest for the period that a determination can cover.

S1140.205 JOINT CHECKING AND SAVINGS ACCOUNTS

A. Introduction

The instructions in S1140.200, except for A.1. (ownership), apply to all checking and savings accounts. The instructions in this section, which apply to joint accounts only, supplement those in S1140.200.

**B. Operating Policy--
Rebuttable
Ownership
Assumptions**

**1. Account Holders
Include One Or
More
Applicants or
Recipients and
No Deemors**

Assume that all the funds in the account belong to the applicant(s)/recipient(s), in equal shares if there is more than one applicant or recipient.

**2. Account Holders
Include One or
More Deemors**

Provided that none of the account holders is an applicant or recipient (in which case the assumption in 1. above would apply), assume that all the funds in the account belong to the deemor(s), in equal shares if there is more than one deemor.

**C. Development and
Documentation--
Initial Applications
and Posteligibility**

**1. Informing the
Individual**

Inform the individual:

- of the applicable ownership assumption;
- of the corresponding income implications (S0810.130); and
- of his or her right to provide evidence rebutting the ownership assumption, if he or she disagrees with it.

**2. Individual
Wishes to Rebut**

a. Rebuttal Statement

If an individual wishes to rebut the applicable ownership assumption, obtain his or her statement, regarding:

- who owns the funds;
- why there is a joint account;
- who has made deposits to and withdrawals from the account; and
- how withdrawals have been spent.

b. Required Evidence

In addition, inform the individual that he or she must submit the following evidence:

- a corroborating statement from each other account holder (if the only other account holder is incompetent or a minor, have the individual submit a corroborating statement from anyone aware of the circumstances surrounding establishment of the account);
- account records showing deposits, withdrawals and interest in the months for which ownership is at issue;
- if the individual owns *none* of the funds, evidence showing that he or she can no longer withdraw funds from the account;
- if the individual owns only a portion of the funds, evidence showing removal from the account of such funds, or removal of the funds owned by the other account holder(s), and redesignation of the account.

c. Determination

Any funds that the evidence establishes were owned by the other account holder(s), and that the individual can no longer withdraw from the account, were not and are not the individual's resources. However, such funds can be deemed available to the individual if the account holder to whom they belong is a deemor. Document the determination in file.

NOTE: You must verify joint account balances if an individual rebuts ownership of any of the funds in an account.

S1140.210 TIME DEPOSITS

A. Introduction

1. Time Deposits

A time deposit is a contract between an individual and a financial institution whereby the individual agrees to leave funds on deposit for a specified period (six months, two years, five years, etc.) and the financial institution agrees to pay interest at a specified rate for that period. Certificates of deposit (C.D.s) and savings certificates are common forms of time deposits.

QDWI (QUALIFIED DISABLED AND WORKING INDIVIDUALS)**A. Introduction**

This appendix contains the policy regarding resources that are treated differently for the QDWI covered group. The resource policy for QDWI individuals is identical to SSI resource policy. The policy in this appendix applies to QDWI evaluations only.

B. QDWI Resource Evaluation

Resource treatment and evaluations used in QDWI evaluations are listed in:

- S1110 Resources, General;
- S1120 Identifying Resources;
- S1130 Resource Exclusions; and
- S1140 Countable Resources.

C. Resources Treated Differently

The following types of resources are treated differently for QDWI individuals. The differences are:

- automobiles*
- burial fund exclusions - maximum amount of \$1,500
- burial plots - only one space per individual and immediate family members
- home property*
- household goods and personal effects*
- inheritances and unprobated estates*
- life estates*
- real property whose sale would cause undue hardship, due to loss of housing, to a co-owner*
- real property following reasonable but unsuccessful efforts to sell

The policy for counting resources marked with an asterisk is contained in this appendix.

D. References

Information on how to treat other types of resources of a QDWI individual is found within each of the following sections:

M1130.400 Burial Spaces
S1130.410 Burial Fund Exclusions
M1140.110 Countable Life Estate Interest

DETERMINING QDWI ELIGIBILITY BASED ON RESOURCES

S1110.600 FIRST-OF-THE-MONTH (FOM) RULE FOR MAKING DETERMINATIONS

- A. Policy Principle -- the FOM Rule** We make all resources determinations as of the first moment of a calendar month.
- B. Policy Principle -- Significance of the FOM Rule**
- 1. Increase in Value of Resources** We consider any increase in the value of an individual's resources in the resources determination as of the first moment of the month following the month in which:
 - the value of an existing resource increases (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
 - an individual acquires an additional resource (e.g., inherits property); or
 - an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcluded cash).
 - 2. Decrease in Value of Resources** We consider any decrease in the value of an individual's resources in the resources determination as of the first moment of the month following the month in which:
 - the value of an existing resource decreases (e.g., the value of a share of stock goes down);
 - an individual spends a resource (e.g., withdraws \$150 from a savings account to pay bills); or
 - an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).
 - 3. Treatment of Assets Under Income and Resources Counting Rules** When an individual receives something in cash or in kind during a month, we evaluate it under the appropriate income-counting rules in that month. If the individual retains the item into the month following that of receipt, we evaluate it under the resource-counting rules. Thus, we do not evaluate the same asset under two sets of counting rules for the same month.
 - 4. Receipts from the Sale, Exchange, or Replacement of a Resource** If an individual sells, exchanges, or replaces a resource, what he/she receives in return is not income. It is a different form of resource. This includes assets which have never been subject to resources counting because the owner sold, exchanged, or replaced them in the same month in which he/she received them.

The concept of such transactions not producing income does not apply to receipts from the sale of timber, minerals, or other like items which are part

- clothing; or
- household furnishings of little value.

**C. Development and Documentation--
Initial Claims**

1. Wedding And Engagement Rings

If only one wedding and/or engagement ring per individual is alleged, exclude it without further development. Treat additional such rings in accordance with the instructions below.

2. Allegation Of No Items Of Unusual Value, Or Of Only One Such Item With A CMV of \$1,000 Or Less

Absent evidence to the contrary, accept the allegation. Assume that the total equity value of all household goods and personal effects is \$2,000 or less. No further development is required.

3. Allegation Of Items Of Unusual Value Whose Total CMV Exceeds \$1,000

a. Ask if the individual's physical condition requires any of the items. If the answer is "No," record it in the *case record* and skip to c. below for the additional development required.

If the answer is "Yes," record it in the case record with the following information:

- what the condition is;
- why the item is required for that condition (unless the reason is obvious);
- the extent to which the individual uses the item; and
- the extent to which any other member of the household uses the item.

b. Determine, based on the allegations, whether any of these items is excluded per A.1.b. above.

If, after exclusion of appropriate items per A.1.b., the alleged total CMV of the remaining items of unusual value does not exceed \$1,000, **discontinue development**. Otherwise, proceed according to c. below.

c. Have the individual list all durable items and the estimated value of each. If the sum of their alleged value and the alleged value of the nonexcluded items of unusual value does not exceed \$2,000, **cease development**. If it does exceed \$2,000, proceed according to d. below.

d. Verify the CMV of any item of unusual value not excluded per A.1.b. Use any reliable evidence of CMV the individual can submit, such as a recent sales slip or appraisal, or insurance coverage, or obtain an estimate from a knowledgeable source, such as a local merchant.

NOTE: Insurance appraisals and amounts of insurance coverage often reflect replacement value (the amount it would cost to purchase a

similar item new) rather than CMV. Do not use replacement value in lieu of CMV.

If the verified CMV of all nonexcluded items of unusual value and the alleged CMV of all durable items totals \$2,000 or less, **cease development**. Otherwise, proceed according to e. below.

- e. **Determine** whether any of the durable items (i.e., that are not items of unusual value) can be excluded per A.1.b. above. If they can, and if the verified CMV of all nonexcluded items of unusual value and the alleged CMV of the remaining durable items then totals \$2,000 or less, **cease development**. Otherwise, proceed according to f. below.
- f. **Verify** the CMV of the nonexcluded durable items. If the verified total CMV of all nonexcluded items of unusual value and nonexcluded durable items is \$2,000 or less, **cease development**. Otherwise, proceed according to g. below.
- g. If the portion of the total CMV that exceeds \$2,000 affects eligibility, **determine** the equity value of any item on which the individual alleges there is an encumbrance. If total equity value then exceeds \$2,000, that portion of the equity in excess of \$2,000 cannot be excluded under this provision.

S1140.110 OTHER PROPERTY RIGHTS

A. Introduction

For resources other than a life estate, apply development and documentation located in S1140.110 to QDWI evaluations.

B. Life Estate

A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate but does not have title to the property and thus, normally cannot sell it or pass it on as an inheritance.

*For QDWI evaluations, a life estate in real property, other than the home property, is counted as a resource **regardless of when the life estate was established**. Follow the policy in M1140.110 for determining the countable value of a life estate.*

A life estate in home property does not need to be developed as the home is an excluded resource.

**M1370.000 SPENDDOWN - ABD MEDICALLY INDIGENT
(EXCLUDING ABD 80% FPL)****M1370.100 SPENDDOWN - ABD MEDICALLY INDIGENT****A. Introduction**

This policy applies to aged, blind or disabled (ABD) medically indigent (MI) recipients in one of the following groups:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low-income Medicare Beneficiaries (SLMBs),
- Qualified Individuals (QIs), and
- Qualified Disabled Working Individuals (QDWIs).

These ABD MI recipients are eligible for only a limited package of Medicaid services. They do not receive full Medicaid coverage, therefore they must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown.

This policy does not apply to individuals in the ABD 80 % FPL covered group. Individuals in the ABD 80% FPL covered group receive full Medicaid coverage.

**1. Placed on
Spenddown**

At application and redetermination, QMB, SLMB, and QDWI medically indigent recipients who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month certification period. They may also be eligible for retroactive MN spenddown eligibility.

When only one spouse of an ABD couple is eligible as ABD MI (i.e., one spouse has Medicare and the other does not), the couple is an assistance unit of two for spenddown purposes and placed on two six-month spenddowns.

**2. QMB, SLMB,
and QDWI**

If an enrolled QMB, SLMB, or QDWI does not meet the spenddown, he continues to be eligible as ABD MI. If he remains eligible as ABD MI, the ABD Medicaid Renewal form (#032-03-0186) may be used as an application for establishing additional spenddown budget periods. The Eligibility Review Part A (#032-03-729A) and the Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits.

The spenddown budget period is based on the application date. At renewal, the new spenddown budget period begins the month following the end of the previous spenddown budget period if the renewal is filed in the last month of the spenddown budget period or the following month. If the renewal is filed two or more months after the end of the last spenddown budget period, the new spenddown budget periods (retroactive or prospective) are based on the date the renewal form was received in the LDSS. Do not complete an early renewal on a spenddown case because the spenddown period must not be shortened by the completion of an early renewal.

3. **QI** The QI medically indigent recipients who meet the MN covered group and resource requirements are placed on a MN spenddown. If an enrolled QI medically indigent recipient does not meet the spenddown, he continues to be eligible as QI for the calendar year, or as long as the program is funded. He must file an Application for Benefits (#032-03-824) to reapply as a medically indigent Qualified Individual and to establish a new spenddown budget period.

- B. References** The spenddown eligibility determination and enrollment procedures for an ABD MI recipient are contained in the following sections:
- M1370.200 Qualified Medicare Beneficiaries (QMBs), Special Low-income Medicare Beneficiaries (SLMB), & Qualified Disabled Working Individuals (QDWIs).
 - M1370.300 Qualified Individuals (QI)

M1370.200 QMBs, SLMBs & QDWIs

- A. Policy** QMBs are eligible only for Medicaid coverage of their Medicare premiums, the Medicare deductible and coinsurance charges for Medicare covered services. Medicare does not cover all of the services that Medicaid covers. For example, Medicare does not cover *non-emergency transportation*.

SLMBs and QDWIs are eligible only for Medicaid coverage of their Medicare premiums.

- B. Entitlement After Meeting Spenddown** When an enrolled QMB, SLMB or QDWI meets a medically needy spenddown, he is eligible for Medicaid as medically needy beginning the date the spenddown was met and ending the last day of the spenddown budget period.

- C. Enrollment Procedures** The MMIS enrollment must be canceled and then reinstated in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:

1. **Cancel ABD MI Coverage** **Cancel** the recipient's current coverage line that has the medically indigent *aid category (AC)*.
 - a. Cancel date is the date **before** the date the spenddown was met.
 - b. Cancel reason is "024".
2. **Reinstate MN Coverage** Reinstate the recipient in the appropriate medically needy aid category (AC).
 - enter the eligibility begin date as the date the spenddown was met.
 - enter the eligibility end date - the date the spenddown budget period ends.

Be sure that the application date is the first month in the spenddown budget period. The MMIS will cancel eligibility effective the end date entered.

D. Continuing Eligibility and Enrollment After Spenddown Ends

When the spenddown budget period ends, reinstate the recipient's Medicaid eligibility as medically indigent beginning the day after the MN spenddown budget period eligibility cancel date. Use the original Medicaid application date. ABD MI eligibility resumes the first day of the month following the end of the spenddown budget period. The month in which the spenddown budget period ends is considered the month in which the agency determines the recipient's ABD MI eligibility.

To establish a new spenddown budget period, use the Medicaid Renewal form (#032-03-669). The "Eligibility Review Part A" (#032-03-729A) and "Eligibility Review Part B" (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits. When the annual redetermination is filed, new spenddown budget periods are established. Eligibility for each spenddown budget period is evaluated.

E. Example--QMB Meets Spenddown

EXAMPLE #1: Mr. B is 69 years old. He has Medicare Parts A & B. He applied for Medicaid on July 14, 2005. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QMB limit. His eligibility is determined on August 1, 2005. He is enrolled in Medicaid QMB coverage effective September 1, 2005, the month following the month the agency determined his QMB eligibility. He is placed on two consecutive 6-month spenddown budget periods, July 1, 2005 through December 31, 2005 and January 1 through June 30, 2006. The agency enrolls him in the MMIS with an eligibility begin date of September 1, 2005, AC 023.

On September 15, 2005, he brings in prescription drug bills. He meets the spenddown on September 13, 2005. On September 25, 2005, the agency cancels his QMB coverage (AC.023) effective September 12, 2005. He is reinstated with MN Medicaid eligibility as AC 028 (dual-eligible medically needy aged) with a begin date of September 13, 2005, an application date of July 14, 2005, and an end date of December 31, 2005.

His spenddown eligibility ends December 31, 2005. On January 1, 2006, the agency worker reinstates his QMB-only Medicaid coverage with a begin date of January 1, 2006, AC 023, application date July 14, 2005. He remains on a spenddown for the spenddown budget period January 1, 2006 through June 30, 2006.

M1370.300 Qualified Individuals (QI)

A. Introduction

QIs are eligible only for limited Medicaid payment of their Medicare premiums. They are NOT eligible for any other Medicaid-covered services.

If all eligibility factors are met in the application month, eligibility for Medicaid as QI begins the first day of the application month and ends December 31 of the calendar year, if funds are still available.

- B. Entitlement After Meeting Spenddown** When an enrolled QI meets a spenddown, he is eligible for Medicaid as medically needy. MN eligibility begins the date the spenddown was met and ends the last day of the spenddown budget period.
- C. Enrollment Procedures**
- The MMIS ABD MI enrollment must be canceled and the MN coverage reinstated in order for him to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is MN-eligible. Take the following actions:
1. **Cancel QI Coverage**

Cancel the recipient's current eligibility in the QI aid category.

 - a. Cancel date is the date before the date the spenddown was met.
 - b. Cancel reason is "024".
 2. **Reinstate MN Coverage**

Reinstate the recipient in the appropriate MN AC (**NOT dual-eligible**).

 - enter the eligibility begin date as the date the spenddown was met.
 - enter the end date as the last date of the spenddown budget period.

Be sure that the application date is the first month in the spenddown budget period. The MN coverage will end the last date of the spenddown budget period.
- D. Continuing Eligibility and Enrollment After Spenddown Ends**
- When the spenddown budget period ends, reinstate the recipient's Medicaid eligibility as medically indigent QI beginning the day after the MN spenddown eligibility cancel date. Use the initial Medicaid application date. The QI medically indigent coverage begin date is the first day of the month following the end of the spenddown budget coverage period.
- The QI must file a new application in order to be placed on a new MN spenddown budget period.
- E. Example- QI Meets Spenddown**
- EXAMPLE #2:** Mr. P is 69 years old. He has Medicare Parts A & B, and applied for Medicaid on May 14. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QI limit. His eligibility is determined on June 1. He is enrolled in Medicaid QI coverage beginning May 1. He is placed on a spenddown for the budget period May 1 through October 31. The agency enrolls him in the MMIS with an eligibility begin date of May 1, AC 056.
- On July 15 he brings in prescription drug bills. He meets the spenddown on July 13. On July 25 the agency cancels his QI (AC 056) coverage effective July 12. His Medicaid eligibility as MN is reinstated using AC 018 (medically needy aged) with an application date May 14, eligibility begin date of July 13, and eligibility end date of October 31.
- His spenddown eligibility ends October 31. On November 1, the agency worker reinstates his QI Medicaid coverage with a begin date of November 1, AC 056, application date May 14. He must file an "Application for Benefits" to establish a new spenddown for the spenddown budget period November 1 through April 30.

M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term care (LTC) services. The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay - Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care.

1. Authorized Representative

An **authorized representative** is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's

- spouse
- parent, if the individual is a child under age 18 years
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (formerly known as the committee)
- trustee.

EXCEPTION: Patients in the Department of Mental Health, Mental Retardation, & Substance Abuse Services (DMHMRSAS) facilities may have applications submitted by DMHMRSAS staff.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- Medicaid Community-Based Care (CBC) services; or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 days begins with the day of admission to the medical institution or receipt of Medicaid CBC. The date of discharge into the community (not in LTC) or death is **NOT** included in the 30 days.

The institutionalization provisions may be applied when the individual is already in a medical facility at the time of the application, or the

individual has been screened and approved to receive LTC services and it is anticipated that he is likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.

The 30-consecutive-days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC). This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of LTC services, the worker must have received the DMAS-96 that was signed by the supervising physician or the signed Waiver Level of Care form. Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.

The worker must verify that LTC services started within 30 days of the date on the Notice of Action on Medicaid. If services do not start within 30 days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed.

For purposes of this definition, continuity is broken by 30 or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of LTC services, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see M1470.350).

3. **Institution** An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.
4. **In An Institution** "**In an institution**" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.
5. **Long-term Care** **Long-term care** is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.

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M1420.000 PRE-ADMISSION SCREENING

M1420.100 PRE-ADMISSION SCREENING *PROCESS*

A. Introduction

The *Medicaid* nursing home pre-admission screening *process* was implemented in 1977 to ensure that Medicaid eligible individuals placed in nursing facilities *met the required level of care for Medicaid payment of long-term care (LTC) services*. In 1982, *the screening process for LTC* was expanded to require pre-admission screening for individuals *requesting Medicaid payment of LTC services through the Medicaid Home and Community-based Care Waivers(CBC) or institutional long-term care*. In 2007, *the screening process was expanded again to require a pre-admission screening for individuals requesting Medicaid payment of LTC services through the Program for the All-Inclusive Care of the Elderly (PACE)*.

This subchapter describes the pre-admission screening process; the eligibility implications; the communication requirements; the inter-agency cooperation requirements; and *eligibility worker responsibilities in the pre-admission screening process*.

B. Operating Policies

1. Payment Authorization

A pre-admission screening provides authorization for Medicaid payment of facility (medical institution), CBC, *and PACE* long-term care services for Medicaid recipients.

2. When a Pre-admission Screening is Required

A pre-admission screening is used to determine if an individual entering LTC care meets the nursing facility level of care criteria, or if living outside of a nursing facility *meets the criteria to receive nursing facility, CBC, or PACE services*. A *pre-admission screening is not needed when an individual is already in a nursing facility or received Medicaid LTC in one or more of the preceding twelve months, and his LTC terminated for a reason other than no longer meeting the level of care*. *The exceptions to the pre-admission screening requirement are listed in M1420.400 B. 1.*

The approval by the screening committee/team for receipt of Medicaid LTC services allows the individual to be evaluated using the eligibility rules for institutionalized individuals. See M1420.100 B.3.

After an individual is admitted to a nursing facility, Medicaid CBC or PACE, the provider is responsible for certifying that the individual continues to meet the level of care for LTC services.

3. Eligibility Rules

The pre-admission screening form is used to determine the appropriate rules used for the eligibility determination (which LTC rules to use, or whether to use non-institutional Medicaid eligibility rules). An individual who is screened and approved for LTC services is treated as an institutionalized individual in the Medicaid eligibility determination. The pre-admission screening document also certifies the type of LTC service and provides information for the personal needs/maintenance allowance.

M1420.200 *RESPONSIBILITY FOR PRE-ADMISSION SCREENING*

A. Introduction

In order to qualify for Medicaid payment of LTC services, an individual must *be determined to* meet both functional and medical components of the level of care criteria *through the pre-admission screening process. The pre-admission screening is completed by a designated screening team or committee. The screening team or committee that completes the pre-admission screening depends on the type(s) of services needed by the individual. Below is a listing of the types of LTC services an individual may receive and the committees/teams responsible for completion of the pre-admission screening certification for those services.*

B. Nursing Facility Screening

This evaluation is completed by local teams composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of acute care hospitals.

The local committees usually consist of the local health department director, a local health department nurse, and a local social services department service worker.

Patients placed directly from acute care hospitals are usually screened by hospital screening teams.

A state level committee is used for patients being discharged from State Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) institutions for the treatment of mental illness, and mental retardation.

Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.

C. CBC Screening

Entities other than hospital or local health committees are authorized to screen individuals for CBC. The following entities are authorized to screen patients for Medicaid CBC:

1. Elderly or Disabled with Consumer-Direction (EDCD) Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the EDCD waiver.

2. Technology-Assisted Individuals (Tech)Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the Tech waiver.

- 3. Mental Retardation (MR) Waiver** Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the MR waiver. Final authorizations for MR waiver services are made by DMHMRSAS staff.
- 4. AIDS Waiver** Local and hospital screening committees or teams are authorized to screen individuals for the AIDS waiver.
- 5. Individual and Family Developmental Disabilities Support (DD) Waiver** DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.
- 6. Alzheimer's Assisted Living (AAL) Waiver** Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record. Documentation of the verbal assurance by the screeners must be included in the case record.
- 7. Day Support Waiver for Individuals with Mental Retardation (DS) Waiver** Local CSB and DMHMRSAS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DMHMRSAS staff.

- D. PACE** Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

- A. Introduction** To ensure that nursing facility/*PACE placement* or receipt of Medicaid CBC services *are* be arranged as quickly as possible, *there must be* prompt communication between screeners and eligibility staff.
- B. Procedures**
- 1. LDSS Contact** *The LDSS agency should* designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and DRS staff *should be given the name and contact information for that person to* facilitate timely communication between screeners and eligibility staff.
- 2. Screeners** Screeners must inform the individual's eligibility worker *when the* screening process has been initiated *and completed*.

**3. Eligibility Worker
(EW) Action**

The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTC services has been determined. If the individual is found eligible for Medicaid and verbal or written assurance of approval by the screening committee has been received, the eligibility worker must give the LTC provider the enrollee's Medicaid identification number.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes *the* local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The screening certification is valid for one year.

B. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application;
- *the individual received Medicaid LTC in one or more of the preceding 12 months and LTC was terminated for a reason other than no longer meeting the level of care;*
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility directly from the EDCD/AIDS waiver or PACE ;
- the individual leaves a nursing facility and begins receiving EDCD/AIDS waiver services or enters PACE and *a pre-admission screening was completed prior to the nursing facility admission; or*
- the individual enters a nursing facility from out-of-state.

C. Documentation

If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record *by one of the following documents:*

- *Medicaid Funded Long-term Care Service Authorization Form (DMAS-96) for nursing facilities, PACE and EDCD, Tech and AIDS Waivers (see Appendix 1);*
- *Technology Assisted Waiver Level of Care Eligibility Form (see Appendix 2);*
- MR Waiver Level of Care Eligibility Form (*see Appendix 3*);
- DS Waiver Level of Care Eligibility Form (*see Appendix 4*); or
- DD Waiver Level of Care Form (*see Appendix 5*).

Medicaid payment for CBC services cannot begin prior to the date the screener's certification form is signed and prior authorization of services for the individual has been given to the provider by DMAS or its contractor.

**1. Nursing
Facility/PACE**

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician.

The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under the "Pre-admission Screening" section. These numbers indicate which of these programs was authorized. Medicaid payment of PACE services cannot begin prior to the date the DMAS-96 is signed and dated by the supervising physician and prior-authorization of services for the individual has been given to the provider by DMAS.

2. EDCD Waiver

Individuals screened and approved for the EDCD waiver must have a DMAS-96 signed and dated by the screener and the physician.

If the individual elects consumer-directed services, DMAS or its contractor must give final authorization. If services are not authorized, the service facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

3. Tech Waiver

Individuals screened and approved for the Tech Waiver will have either a DMAS-96 signed and dated by the screener and physician, or a Technology Assisted Waiver Level of Care Eligibility Form signed and dated by a DMAS representative.

**4. MR Waiver
Level of Care
Eligibility Form**

Individuals screened and approved for the MR waiver will have the MR Waiver Level of Care Eligibility Form signed and dated by the DMHMRSAS representative. The MR Waiver Level of Care Eligibility Form will include the individual's name, address and the date of DMHMRSAS approval.

**5. DS Waiver Level
of Care
Eligibility Form**

Individuals screened and approved for the DS waiver will have the DS Waiver Level of Care Eligibility Form signed and dated by the DMHMRSAS representative. The DS Waiver Level of Care Eligibility Form will include the individual's name, address and the date of DMHMRSAS approval.

**6. DD Waiver
Level of Care
Eligibility Form**

Individuals screened and approved for the DD waiver will have the DD Waiver Level of Care Eligibility Form signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services.

**D. Authorization for
LTC Services**

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to determine Medicaid eligibility as an institutionalized individual. However, the appropriate form must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

**1. Authorization
Not Received**

If a pre-admission screening is required and the appropriate documentation is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

**2. Authorization
Rescinded**

The authorization for Medicaid *payment of LTC services* may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet *the required* Medicaid level of care criteria.

When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate *the individual's* eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTC services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, continue to use the eligibility rules for institutional individuals even though the individual no longer meets the level of care criteria. If the individual is eligible for Medicaid, Medicaid will not make a payment to the facility for LTC.

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ____/____/____
Social Security _____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible?
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission OR within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission
If no, has Individual formally applied for Medicaid?
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief
Dept of Social Services: (Eligibility Responsibility)
(Services Responsibility)

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care

- 1 = Nursing Facility (NF) Services
2 = PACE/LTC PHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled w/Consumer Direction (EDCD) Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver
15 = Technology Assisted Waiver
16 = Alzheimer's Assisted Living Waiver

Exceptions: Authorizations for NF, PACE, AIDS or the EDCD Waivers are interchangeable. Screening updates are not required for individuals to move between these services because the alternate institutional placement is a NF. NF = EDCD, AIDS, or PACE Alzheimer's Assisted Living Waiver's alternate institutional placement is a NF, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the NF criteria. NF = Alzheimer's ALF
PACE participants can also meet assisted living facility criteria and reside in an assisted living facility and receive the Auxiliary Grant while accessing PACE services. PACE = NF or ALF

NO MEDICAID SERVICES AUTHORIZED

- 8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF

0 = No 1 = Yes

ALF Reassessment Completed

1 = Full Reassessment 2 = Short Reassessment

ALF provider name:
ALF provider number:
ALF admit date:

SERVICE AVAILABILITY

- 1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home)

- 1 = Temporary (less than 3 months)
2 = Temporary..(less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility, PACE, HIV/AIDS waiver and the EDCD Waiver. The progress notes should be provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION

Name of Level I/ALF screener agency and provider number:

1.
2.

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION

Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1.

- 0 = Not referred for Level II OR 101B assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NH
Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

Table with 3 columns: Role (Level I/ALF Screener, Level I/ALF Screener, Level I Physician), Title, Date



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Suite 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4612 (Fax)
804/343-0634 TDD)

Technology Assisted Waiver Level of Care Eligibility Form

Name:

Address:

City:

Date of Approval by DMAS:

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMAS/ Tech Waiver Unit

Phone: 804-225-4222



COMMONWEALTH of VIRGINIA

Department of
Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797

RICHARD E. KELLOGG
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.state.va.us/dmhmsas/welcome.htm

MR Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMHMRSAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMHMRSAS Representative: _____

Date: _____

Phone: _____



COMMONWEALTH of VIRGINIA

Department of
Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797

RICHARD E. KELLOGG
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.state.va.us/dmhmsas/welcome.htm

DS Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMHMRSAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMHMRSAS Representative: _____

Date: _____

Phone: _____

Confidentiality Statement: This document contains confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this document.



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Suite 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4612 (Fax)
804/343-0634 TDD)

DD Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMAS Health Care Coordinator: _____

Date: _____

Phone: _____

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M1430.000 FACILITY CARE

- A. Introduction** Medicaid covers care provided in a facility to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living.

This subchapter (M1430) contains the specific policy and rules that apply to individuals needing or receiving long-term care (LTC) services in medical institutions (facilities).

- B. Definitions** Definitions for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care are found in Subchapter M1410.

M1430.010 TYPES OF FACILITIES & CARE

- A. Introduction** This section contains descriptions of the types of medical facilities in which Medicaid provides payment for services received by eligible patients.

- B. Medical Facility Defined** A **medical facility** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

- C. Types of Medical Facilities** The following are types of medical facilities in which Medicaid will cover part of the cost of care:

- 1. Chronic Disease Hospitals** **Chronic disease hospitals** are specially certified hospitals, also called "long-stay hospitals". There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C.;
- Lake Taylor Hospital in Norfolk, Virginia.

- 2. Institutions for the Mentally Retarded** An **institution for the mentally retarded or persons with related conditions** is an institution or a distinct part of an institution that

- is primarily for the diagnosis, treatment or rehabilitation of individuals with mental retardation or related conditions, and
- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

Some community group homes are certified as Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) by the Department of Health. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF-MR because ICF-MR services are not covered for the medically needy.

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is NOT an IMD.

NOTE: Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of LTC services in an IMD because these services are not covered for medically needy individuals age 65 or over. For a list of IMDs in Virginia, see Appendix 1 to this subchapter.

NOTE: Any individual over age 21 but under age 65 who is in an IMD is not eligible for Medicaid while residing in the IMD.

4. Nursing Facility

A nursing facility is a medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

5. Rehabilitation Hospitals

A rehabilitation hospital is a hospital certified as a rehabilitation hospital, or a rehabilitation unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1430.100 BASIC ELIGIBILITY REQUIREMENTS

- A. Overview** To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in *Chapter M02* apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.
- B. Citizenship/
Alienage** The citizenship and alien status policy is found in subchapter 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.
- H. Covered Group
(Category)** The Medicaid covered groups eligible for LTC services are listed in M1460. The requirements for the covered groups are found in chapter M03.
- I. Financial
Eligibility** An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been screened and approved for LTC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).

The 30-consecutive-days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC). If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all facility patients.

M1430.101 VIRGINIA RESIDENCE

- A. Policy** An individual must be a resident of Virginia to be eligible for Virginia Medicaid while he/she is a patient in a medical facility. There is no durational requirement for residency. *Additional Virginia residency requirements are in subchapter M0230.*
- B. Individual Age 21 or Older** An institutionalized individual age 21 years or older is a resident of Virginia if:
- the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period; or
 - the individual became incapable of declaring his intention to reside in Virginia at or after becoming age 21 years, he/she is residing in Virginia and was not placed here by another state government agency.
- 1. Determining Incapacity to Declare Intent** An individual is incapable of declaring his/her intent to reside in Virginia if:
- he has an I.Q. of 49 or less or has a mental age of less than 7 years;
 - he has been judged legally incompetent; or
 - medical documentation by a physician, psychologist, or other medical professional licensed by Virginia in the field of mental retardation supports a finding that the individual is incapable of declaring intent to reside in a specific state.
- 2. Became Incapable Before Age 21** An institutionalized individual age 21 years or older who became incapable of stating intent before age 21 is a resident of Virginia if:
- the individual's legal guardian or parent, if the parents reside in separate states, who applies for Medicaid for the individual resides in Virginia;
 - the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
 - the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
 - the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
 - if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

- C. Individual Under Age 21** An institutionalized individual under age 21 years who is not emancipated is a resident of Virginia if:
- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
 - the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
 - the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
 - if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.
- D. Placed by Another State's Government** When an individual is placed in a facility by another (not Virginia) state or local government agency, the placing state retains responsibility for the individual's Medicaid. Placement by a government agency is any action taken by the agency beyond providing general information to the individual and the individual's family to arrange the individual's admission to an institution. A government agency includes any entity recognized by State law as being under contract with the state government.
- E. Individual Placed Out-of-state by Virginia** An individual retains Virginia residency for Medicaid if he/she is placed by a Virginia government agency in an institution outside Virginia. Placement into an out-of-state LTC medical facility must be pre-authorized by DMAS.
- When a competent individual voluntarily leaves the facility in which Virginia placed him/her, he/she becomes a resident of the state where he/she is physically located.
- F. Disputed or Unclear Residency** If the individual's state residency is unclear or is disputed, contact your Regional Coordinator for help. When two states cannot resolve the residency dispute, the state where the individual is physically located becomes his/her state of residency for Medicaid purposes.

M1430.102 ADVANCE PAYMENTS

- A. Introduction** There are instances when a family member, or other individual, makes an advance payment to the facility for a prospective Medicaid patient prior to or during the Medicaid application process. This assures the patient's admission to, and continued care in, the facility. The individual may have been promised by the facility that the advance payment will be refunded if the patient is found eligible for Medicaid.

Advance payments which are expected to be reimbursed to an individual other than the Medicaid applicant once Medicaid is approved, and payments made to the facility to hold the bed while the patient is hospitalized, are not counted as income for either eligibility or patient pay determinations.

- B. Reimbursement** Any monies contributed toward the cost of the patient's care pending Medicaid eligibility determination must be reimbursed to the contributing party by the facility when Medicaid eligibility is established. The only exception is when the payment is made from the patient's own funds which exceeded the resource limit.

M1430.103 SSI RECIPIENTS

- A. Introduction** This section provides information about SSI recipients who are admitted to medical facilities.
- B. Unmarried SSI Recipient** When an unmarried Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and home property ownership.
- 1. Temporary Period** An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.
- 2. Indefinite Period** If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to \$30 per month. If the individual has no other countable income, his SSI payment will usually be \$30 per month. If he has countable income of \$30 or more, his SSI payment will terminate.
- Review his income eligibility when the SSI payment terminates. See M1460.
- C. Married SSI Recipient** When a married Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and resources. Use the married institutionalized individuals' policy in M1480 to determine resource eligibility and patient pay.
- 1. Temporary Period** An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, usually retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.
- 2. Indefinite Period** If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to \$30 per month. If the individual has no other countable income, his SSI payment will usually be \$30 per month. If he has countable income of \$30 or more, his SSI payment will terminate. Review his income eligibility when the SSI payment terminates. See M1460.

List Of IMDs In Virginia

Catawba Hospital
P.O. Box 200
Catawba, VA 24070

Central State Hospital
P.O. Box 4030
Petersburg, VA 23803

(NOTE: Hiram Davis Medical Center is not an IMD)

Eastern State Hospital
P.O. Box 8791
Williamsburg, VA 23187

Northern Virginia Mental Health Institute
3302 Gallows Road
Falls Church, VA 22046

Piedmont State Hospital
Burkeville, VA 23922

Southern Virginia Mental Health Institute
382 Taylor Drive
Danville, VA 24541

Southwestern VA Mental Health Institute
502 E. Main Street
Marion, VA 24354

Western State Hospital
301 Greenville Avenue
Staunton, VA 24401

M1440.106 ALZHEIMER'S ASSISTED LIVING WAIVER

A. General Description

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. **Individuals on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.**

The AAL waiver serves persons who are:

- Auxiliary Grants (AG) recipients,
- have a diagnosis of Alzheimer's or a related dementia and no diagnosis of mental illness or mental retardation, and
- age 55 or older.

B. Eligibility Rules

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements.

The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

C. Services Available

Services available under the AAL waiver are:

- assistance with activities of daily living
- medication administration by licensed professionals
- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Assessment and Service Authorization

Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.

M1440.107 INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER (DD WAIVER)

A. General Description

The Individual and Family Developmental Disabilities Support Waiver (DD waiver) provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of mental retardation. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

This waiver serves persons who:

- have a diagnosis of developmental disability attributable to cerebral palsy, epilepsy or autism, or
- any condition other than mental illness, found to be closely related to mental retardation.

The developmental disability must have been manifested prior to the individual reaching age 22 and must be likely to continue indefinitely.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available

Services available under the DD waiver are:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

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a transfer for less than fair market value and no penalty period will be calculated.

Assets transferred on or after February 8, 2006, that have a total cumulative value of more than \$1,000 but less than or equal to \$4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

I. LTC Partnership Policy

The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.

J. Return of Asset

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

K. Home Foreclosure

The repossession and/or sale of a home by the mortgage lender for less than fair market value due to foreclosure is not evaluated as an uncompensated transfer. Documentation of the foreclosure must be retained in the case record.

L. Undue Hardship Policy

Policy for claiming undue hardship was moved to M1450.700.

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over \$1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed \$1,500,
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income.

B. Procedures

Use the following sections to evaluate an asset transfer:

- M1450.510 for a purchase of term life insurance.
- M1450.520 for a purchase of an annuity before February 8, 2006.

- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

1. Policy Funds Pre-need Funeral

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid recipient.

2. Policy Funds Irrevocable Trust

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

3. Determine If Transfer Is Uncompensated

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

- a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."
- b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."
- c. Compare the result to the term insurance policy's face value.
 - 1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.
 - 2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

EXAMPLE #1: Mr. C. uses \$5,000 from his checking account to purchase a \$5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

The \$100 and \$500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established (\$100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is \$100,000.

The 7-2-96 transfer of \$10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is \$10,000.

D. Pooled Trusts

A pooled trust is a trust that can be established for a disabled individual under the authority of Section 1917(d)(4)(C) of the Social Security Act (see M1120.202). The placement of an individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts.

A trust established for a disabled individual under age 65 years is exempt from the transfer of assets provisions. However, any funds placed in the trust after the individual turns 65 must be evaluated as an asset transfer.

M1450.560 INCOME TRANSFERS

A. Policy

Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

B. Procedures

Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

M1450.570 SERVICES CONTRACTS

- A. Policy** Services contracts (i.e. personal care contract, care contracts, etc.) are typically entered into for the completion of tasks such as, but not limited to, grocery shopping, house keeping, financial management and cooking, that individuals no longer can perform for themselves. For purposes of Medicaid payment of LTC services, payments made under these types of contracts may be considered an uncompensated transfer of assets.
- B. Procedures** When a services contract, sometimes referred to as a personal care contract, is presented as the basis for a transfer of assets, the eligibility worker must do the following:
- 1. Determine Institutionalization** Determine when the individual met the requirement for institutionalization.
 - 2. Verify Contract Terms and Value of Services** Obtain a copy of the written contract, or written statements verifying the terms of the agreement by all parties. Determine when the agreement was entered into/signed, who entered into/signed the contract and if the contract is legally binding as defined by policy at M1450.003 H. The terms of the contract must include the types of services, rate of payment and the number of hours for each service. The terms must be specific and verifiable. Verification of payments made and services provided must be obtained. Any payment for a service which does not have a fair market value is an uncompensated transfer.
 - 3. Contract Services Must Be Received Before Admission to LTC** A contract for services may have been created prior to or after the individual's entrance into LTC. Once an individual begins receipt of Medicaid LTC services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.
 - 4. Physician Statement Required** A statement must be provided by the individual's physician that indicates the types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.
 - 5. Contract Made By Individual or Authorized Representative** The contract must have been made by the applicant/recipient or his authorized representative.

- 6. Payments Prior To Contract Date** Any payment(s) made prior to the date the contract was signed (if contract is written) or date the contract was agreed upon (if contract is a legally binding oral contract) by all parties is considered an uncompensated transfer.
- 7. Advance Lump Sum Payments Made To Contractor** Certain contracts for services provide an advance lump sum payment to the person who is to perform the duties outlined in the contract. Any payment of funds for services that have not been performed is considered an uncompensated transfer of assets. The Medicaid applicant/recipient has not received adequate compensation, as he has yet to receive valuable consideration.
- 8. Determine Penalty Period** If it is determined that an uncompensated transfer of assets occurred, follow policy in this subchapter to determine the penalty period.

- September 1, 1996 through November 30, 1996 for the asset transferred 9-13-96.
- December 1, 1996 through December 31, 1996 for the asset transferred 12-25-96.

Mrs. E. no longer has excess resources, and she is eligible for Medicaid beginning November 1, 1996. She is not eligible for Medicaid payment of LTC services in November and December 1996. Since the last penalty period ended on 12-31-96, she becomes eligible for Medicaid payment of long-term care services beginning January 1, 1997.

H. Transfers While In An Existing Penalty Period

When additional transfers for less than market value occur during an existing penalty period, recalculate the penalty period using the procedures in item G. above.

I. Transfers After A Penalty Period Ended

When a transfer for less than market value occurs after a penalty period has ended, calculate a new penalty period by dividing the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid, and round down.

For applicants, the penalty date is the first day of the month in which the asset was transferred; for recipients, the penalty date is the first of the month following the month in which the asset was transferred.

EXAMPLE #17: Mr. F. entered a nursing facility on June 13, 1996, and applied for Medicaid on October 14, 1996. When the agency evaluated his application, the worker learned that Mr. F. had transferred real estate assessed at \$10,000 on October 12, 1996. Since the transfer did not meet any of the criteria in M1450.300 and 400, a penalty period for Medicaid payment of long-term care services was determined. The 3-month period ran from October 1, 1996, through December 31, 1996.

On March 10, 1997, while Mr. F. was receiving Medicaid, he disclaimed an inheritance of \$30,000. Since the disclaimer is a transfer that did not occur in another penalty period, the agency calculated a new penalty period. The penalty date is April 1, 1997, the first day of the month following March 1997, the month in which the transfer occurred. The new period is 11 months from April 1, 1997 through February 28, 1998. Therefore, Mr. F. was ineligible for Medicaid payment of long-term care services from October 1, 1996 through December 31, 1996, and is ineligible for Medicaid payment of long-term care services from April 1, 1997 through February 28, 1998.

J. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by his/her spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. One of two actions may be taken by the couple:

- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A. enters a nursing facility and applies for Medicaid. Mrs. A. transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A. enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A. still has 24 months to run. Because Mrs. A. is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A. decide to have the penalty period divided between them. Therefore, both Mr. A. and Mrs. A. are ineligible for Medicaid payment of LTC services for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A. leaves the facility and is no longer institutionalized. Mrs. A. remains institutionalized. Because Mr. A. is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A. and 6 months for Mrs. A.), must be imposed on Mrs. A. If Mr. A. becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice.

M1450.630 PENALTY PERIOD FOR TRANSFERS ON OR AFTER FEBRUARY 8, 2006

A. Policy

The policy in this section applies to actions taken on applications, renewals or changes processed on or after July 1, 2006 for transfers made on or after February 8, 2006. The DRA enacted significant changes to the implementation date of the penalty period. When the transfer is made prior to the request for Medicaid LTC, the penalty period does not begin until the individual is eligible for Medicaid LTC. Penalty periods are assessed for fractional portions of a month. The number of months is not rounded down; therefore, the penalty period may end on a day during the month.

B. Penalty Date

When a transfer of an asset made on or after February 8, 2006, affects eligibility, the period of ineligibility for Medicaid payment for long-term care services, begins the **later** of:

- the first day of the month *following the month in which the asset transfer occurred*; or
- the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level of care but for the application of the penalty period; and

**C. Example #21
Partial
Compensation
Received**

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth \$40,000 to her son and received no compensation in return for the property. Ms. H's Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H's son paid her \$20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of \$20,000 and a penalty period of 4 months, beginning October 1, 2004, and continuing through January 31, 2005.

The \$20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. *An undue hardship may exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life. An undue hardship may be granted when documentation is provided that shows:*

- *that the assets transferred cannot be recovered, and*
- *that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.*

Applicants, recipients, or authorized representatives may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination **prior** to the eligibility worker taking action to impose a penalty period. The individual has the burden of proof and must provide written evidence to clearly substantiate what was transferred, the circumstances surrounding the transfer, attempts to recover the asset or receive compensation, and the impact of the denial of Medicaid payment for LTC services.

**1. Eligibility
Worker**

The eligibility worker must inform the individual of the undue hardship provisions and, if an undue hardship is claimed, send the claim and supporting documentation to DMAS for evaluation.

The eligibility worker must send a letter to the individual *informing him of each resource transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Hardship Claim Form, available on the VDSS local agency intranet at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, must be included with the letter. The Asset Transfer Hardship Claim Form serves as the request for an undue hardship evaluation. When requesting an undue hardship, the individual must provide the following documentation:*

- *the reason(s) for the transfer;*
- *attempts made to recover the asset, including legal actions and the results of the attempts;*
- *notice of pending discharge from the facility or discharge from CBC services due to denial or cancellation of Medicaid payment for these services;*
- *physician's statement that inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;*
- *documentation that individual would not be able to obtain, food, clothing or shelter;*
- *list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and*
- *documents such as deeds or wills if ownership of real property is an issue.*

The individual must be given 10 calendar days to return the completed form and documentation to the local agency.

If an undue hardship is claimed, the eligibility worker must send:

- *a copy of the undue hardship claim form*
- *a description of each transfer*
 - *what was transferred*
 - *parties involved and relationship*
 - *uncompensated amount*
 - *date of transfer*

- *the penalty period(s)*
- *a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community), and*
- *other documentation provided by the applicant/recipient*

to DMAS at the following address:

DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record. If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

Note: If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. A copy of the decision must be retained in the individual's case record.

M1450.800 AGENCY ACTION

- A. Policy** If an institutionalized individual's asset transfer is not allowable by policy, the individual is eligible for Medicaid but is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for Medicaid payment of long-term care services.
- B. Procedures** The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

- A. Policy** Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.
- B. Notice Contents** The Notification of Action on Medicaid sent to the individual must specify:
- the individual is eligible for Medicaid beginning (the appropriate date) and
 - Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred (date/dates).
 - the penalty period may be shortened if compensation is received.
- C. Advance Notice** When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify:
- the individual is eligible for Medicaid.
 - Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
 - The penalty period may be shortened if compensation is received.

M1450.820 PROVIDER NOTICE

- A. Introduction** Use the DMAS-122 to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. DMAS-122

The DMAS-122 form includes:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date;
- the patient's income;
- no deductions of patient pay amounts, and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

M1450.830 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the MMIS that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the DMAS-122 sent to the provider.

B. Copy of DMAS-122

The copy of the DMAS-122 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-122:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice

The agency worker must send a copy of the DMAS-122 to:

Program Delivery Systems
Long-Term Care Unit
Department of Medical Assistance Services
600 E. Broad St., Suite 1300
Richmond, VA 23219.

The copy of the DMAS-122 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

2. Institutionalization

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services (see M1410.010).

NOTE: For purposes of this definition, continuity is broken by 30 or more consecutive days of:

- absence from a medical institution, or
- non-receipt of Medicaid waiver services.

EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual, in the covered group of individuals in medical institutions with income less than or equal to 300% of SSI.

*The date of discharge from a medical institution into the community (and not receiving CBC waiver services) or death is **NOT** included in the 30 days.*

3. Home Property

The home property is defined based on the individual's covered group, except when the individual is married with as community spouse. When the individual is married with a community spouse, **go to subchapter M1480.**

a. ABD Groups

The home property definition in section M1130.100 applies to ABD covered groups. An individual's home is property that serves as his or her principal place of residence. A home shall mean the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000. If the individual has property contiguous to his home, the value of the non-home contiguous property over \$5,000 is a countable resource, unless it can be excluded for another reason listed in subchapter S1130.

b. F&C Groups

The home property definition in section M0630.115 applies to F&C covered groups. Home property is the home used as the principal residence and all contiguous property. Contiguous property is the land, and improvements on that land, which adjoins the home and which is not separated by land owned by others.

4. Former Home

The patient's former home (including a mobile home) is his primary residence:

- which he owns, and
- which he occupied as his residence prior to admission to an LTC facility, or prior to moving out to receive Medicaid CBC waiver services services in another person's home.

C. Exclude Former Home Indefinitely

The former home property can be excluded indefinitely when one of the following conditions is met:

1. Occupied By Spouse or Minor Child

The former home is occupied by the individual's spouse, minor dependent child under age 18, or dependent child under age 19 if attending school or vocational training.

2. Occupied By Disabled Adult Child or Disabled Parent

The former home is occupied by the individual's parent or adult child who:

- is age 65 years or older (is presumed to be disabled because of age),
- or, if under age 65 years, is disabled according to the Medicaid disability definition;
- lived in the home with the recipient for at least one year prior to the recipient's institutionalization; and
- is dependent upon the recipient for his shelter needs.

6. **Domestic Travel Tickets** Gifts of domestic travel tickets [1612(b)(15)].
7. **Victim's Compensation** Victim's compensation provided by a state.
8. **Tech-related Assistance** Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].
9. **\$20 General Exclusion** \$20 a month general income exclusion for the unit.
EXCEPTION: Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.
10. **PASS Income** Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].
11. **Earned Income Exclusions** The following earned income exclusions are not deducted for the 300% SSI group:
- a. In 2008, up to \$1,550 per month, but not more than \$6,240 in a calendar year, of the earned income of a blind or disabled student child [1612(b) (1)].

In 2009, up to \$1,640 per month, but not more than \$6,600 in a calendar year, of the earned income of a blind or disabled student child
 - b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].
 - c. \$65 of earned income in a month [1612(b) (4)(C)].
 - d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].
 - e. One-half of remaining earned income in a month [1612(b) (4)(C)].
 - f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].
 - g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].
12. **Child Support** Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

13. Native American Funds

The following Native American funds (only exclude for ABD MN groups):

- a. Puyallup Tribe [ref. P.L. 101-41]
- b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
- c. Chippewas of Mississippi [ref. P.L. 99-377]
- d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
- e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
- f. Wyandotte Tribe [ref. P.L. 98-602]
- g. Chippewas of Lake Superior [ref. P.L. 99-146]
- h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
- i. Coshatta Tribe of Louisiana [ref. P.L. 100-411]
- j. Wisconsin Band of Potawatomi [ref. P.L. 100-581]
- k. Seminole Indians [ref. P.L. 101-277]
- l. receipts from land distributed to:
 - Pueblo of Santa Ana [ref. P.L. 95-498]
 - Pueblo of Zia [ref. P.L. 95-499].

14. State/Local Relocation

State or local relocation assistance [1612(b) (18)].

15. USC Title 37 Section 310

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

M1460.620 RESERVED

M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS

A. Policy - Individual in An Institution for Less Than 30 Days

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of “institutionalization” is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the “institutionalization” definition.

B. Recipient

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

C. Applicant

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual’s income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual’s income eligibility.

- B. Procedure** Subtract the deduction(s) from gross monthly income in the order presented below:
1. Medicaid CBC Personal Maintenance Allowance (M1470.410)
 2. Dependent Child Allowance (M1470.420)
 3. Medicaid CBC - Incurred Medical Expenses (M1470.430)
- C. Appeal Rights** The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

- A. Individuals** For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance. The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

1. Basic Maintenance Allowance

a. Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver and Day Support (DS) Waiver

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic personal maintenance allowance.

- EDCD Waiver,
- MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

Prior to September 1, 2006, the personal maintenance deduction *was* equal to the monthly SSI payment limit for one person. Effective September 1, 2006, the personal maintenance deduction is equal to 165% of the monthly SSI payment limit for one person. The personal maintenance deduction is:

- January 1, 2008 through December 31, 2008: \$1,051
- January 1, 2009 through December 31, 2009: \$1,112.

Contact a Medical Assistance Program Consultant for the SSI amount in effect for years *prior* to 2008.

b. AIDS Waiver

Patients under the AIDS waiver are allowed a monthly basic personal maintenance allowance that equals 300% of the SSI payment limit for one person (see M0810.002 A. 3.).

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance for Recipients in EDCD, DD, MR or DS Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022) per month.
- 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348) per month.

The total amount of the personal maintenance allowance and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #9: (Using January 2005 figures)

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$ 928.80) to the 200% of SSI maximum (\$ 1,158.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\$ 579.00	CBC personal maintenance allowance
+ 928.80	special earnings allowance
\$ 1,507.80	total personal maintenance allowance

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

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1. After Eligibility is Established Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse’s resources when determining the institutionalized spouse’s Medicaid eligibility. Do not count or deem the community spouse’s resources available to the institutionalized spouse.

If an institutionalized spouse’s Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

C. “Institutionalized Spouse Resource Eligibility Worksheet” Use the “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm to determine the institutionalized spouse’s resource eligibility.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse’s initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard	\$21,912	1-1-09
	\$20,880	1-1-08

C. Maximum Spousal Resource Standard	\$109,560	1-1-09
	\$104,400	1-1-08

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

If the applicant is not eligible in the month of application, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible. NOTE: Established application processing procedures and timeframes apply.

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined, the community spouse's protected resource amount (PRA) and the institutionalized spouse's partnership policy disregard amount (see M1460.160) is equal to or less than \$2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources.** Use the policy and procedures in section M1480.230 B.2 to determine the institutionalized individual's financial eligibility.

b. Medicaid Eligibility For LTC Services Not Previously Achieved

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.
- Deduct a dollar amount equal to the Partnership Policy disregard, if any.

B. Procedures

Use the following criteria to determine Medicaid eligibility for any month in the initial eligibility determination period.

NOTE: The initial eligibility determination period begins with the month of application. If the institutionalized spouse is not eligible in that month, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible.

1. Couple's Total Resources

Verify the amount of the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined. The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the spousal share is \$0. The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order**;
- an amount designated by a DMAS Hearing Officer.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). *If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.*

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.240 below.

C. Example--Using the “Institutionalized Spouse Resource Eligibility Worksheet” To Calculate the PRA

EXAMPLE #4: (The “Worksheet” is in Appendix 4 to this subchapter)

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1: The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were \$130,000.

Step 2: $\$130,000 \div 2 = 65,000$. The spousal share is \$65,000.

Step 3: The couple's total countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined), are \$67,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- \$65,000 (the spousal share, which is less than the maximum spousal resource standard of \$79,020 in December 1997, the time of application).
- \$15,804 (the spousal resource standard in December 1997, the time of the application).
- \$0 (court-ordered spousal support resource amount or DMAS hearing decision amount; there is neither in this case).

Since \$65,000 is the greatest, \$65,000 is the PRA.

Step 5: Deduct the PRA from the couple’s combined countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined).

\$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined (December 1, 1997)
- 65,000	Step 4 PRA
\$2,000	countable resources in month for which eligibility is being determined (December 1, 1997).

The remaining \$2,000 is the countable resources available to the institutionalized spouse *on December 1, 1997 (the first moment of the first month for which eligibility is being determined)*.

Step 6: Compare the \$2,000 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are equal to the limit and he is resource eligible in December *(the month for which eligibility is being determined)*. A CSRA and protected period of eligibility are determined in section M1480.240 and 241 below.

D. Example--PRA Is Amount Transferred Per Court-Ordered Spousal Support

EXAMPLE #5: Mr. B applied for Medicaid on January 2, 1998. He was admitted to a nursing facility on December 20, 1996. He is married to Mrs. B who lives in their community home. This is Mr. B's first application for Medicaid as an institutionalized spouse. The court ordered him to transfer \$68,000 of his resources to Mrs. B as spousal support; he transferred \$68,000 to her on December 5, 1997. *Mr. B. is not requesting retroactive coverage.*

Step 1: The couple's total countable resources as of December 1, 1996 (the first moment of the first day of the first continuous period of institutionalization) were \$130,000.

Step 2: $\$130,000 \div 2 = \$65,000$. The spousal share is \$65,000.

Step 3: The couple's total *countable* resources as of January 1, 1998 *(the first moment of the first day of the month for which eligibility is being determined)* are \$67,000.

Step 4: *Determine the spousal protected resource amount (PRA).* The spousal PRA is the greatest of:

- \$65,000 (the spousal share, which is less than the maximum spousal resource standard of \$80,760 in the application month);
- \$16,152 (the spousal resource standard at the time of the application);
- \$68,000 amount actually transferred to community spouse pursuant to court-ordered spousal support;
- \$0 DMAS hearing decision amount (there is none in this case).

Since \$68,000 is the greatest, \$68,000 is the PRA.

Step 5: *Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined).*

:

\$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
-	Step 4 PRA
68,000	countable resources in month for which eligibility is being determined (January 1, 1998).
\$ 0	

Step 3: The couple's total countable resources on November 1, 1996 (first moment of the first day of the month for which eligibility is being determined) are \$80,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

\$75,000 (the spousal share, which is less than the maximum spousal resource standard of \$76,740 in November 1996);

Step 5: Deduct the PRA from the couple's combined countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined).

\$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 75,000	Step 4 PRA
\$ 5,000	countable resources in month for which eligibility is being determined.

\$5,000 is the countable resources available to the institutionalized spouse in the month for which eligibility is being determined.

Steps 6 & 7: Compare the \$5,000 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse exceed the limit, so he is not eligible for Medicaid in November 1996 (the month for which eligibility is being determined). He is not a QMB, so his application was denied in January 1997 because of excess resources.

Mrs. C appealed the denial because she believes that she needs more resources protected so that her income will be sufficient to meet her needs. After a hearing in March 1997, and evidence gathered of Mrs. C's extraordinary shelter and medical expenses, the DMAS Hearing Officer decided that more of the couple's resources should be protected in order to raise Mrs. C's income to the minimum monthly maintenance needs allowance (MMMNA). The Hearing Officer decided that the spousal resource maximum of \$76,740 should be the PRA. Mr. C's eligibility was recalculated using the \$76,740 PRA.

Step 5 again: The revised PRA was deducted from the couple's total combined countable resources in November 1996 (the initial month for which eligibility is being determined):

\$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 76,740	Step 4 PRA
\$3,260	countable resources in month for which eligibility is being determined.

\$3,260 is the countable resources available to Mr. C in November 1996 (the month for which eligibility is being determined). Because he has excess resources, and because he is not a QMB (has no Medicare Part A), he is not eligible for Medicaid and the denial was sustained.

M1480.233 INITIAL ELIGIBILITY - RETROACTIVE MONTHS

A. First Application

Use the procedures for the initial resource eligibility determination (section M1480.232 above) for each of the three (3) months preceding an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

To determine the institutionalized spouse's countable resources in each retroactive month, subtract the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month**. Use the procedures in C below.

B. Subsequent Applications

1. Medicaid Eligibility Established Previously

If an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources**. Use only the institutionalized spouse's resources. Use the policy and procedures in section M1480.230 B.2 to determine the institutionalized individual's financial eligibility.

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

2. Medicaid Eligibility Not Previously Established

If an individual has never established Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination (section M1480.232 above).

- Determine countable resources for the application month (see section M1480.232 above).
- Deduct the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month**.
- Deduct a dollar amount equal to the Partnership Policy disregard as of **the month of application** (Note: this amount is also used when determining eligibility for a retroactive month).

For the application's retroactive month(s), determine resources using the procedures in subsection C below.

C. Procedures

The procedures in this subsection are used for the retroactive determination based on a

- first application; or
- subsequent application when Medicaid eligibility as an institutionalized spouse was NOT previously established.

M1480.350 SPENDDOWN ENTITLEMENT

- A. Entitlement After Spenddown Met** When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.
- B. Procedures**
- 1. Coverage Dates** Coverage begin date is the first day of the month; the coverage end date is the last day of the month.
- 2. Aid Category**
- a. If the institutionalized spouse does NOT have Medicare Part A:**
- Aged = 018
 - Blind = 038
 - Disabled = 058
 - Child Under 21 in ICF/ICF-MR = 098
 - Child Under Age 18 = 088
 - Juvenile Justice Child = 085
 - Foster Care/Adoption Assistance Child = 086
 - Pregnant Woman = 097
- b. If the institutionalized spouse has Medicare Part A:**
- Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):
- 1) When income is less than or equal to the QMB limit, enroll using the following ACs:
- Aged = 028
 - Blind = 048
 - Disabled = 068
- 2) When income is greater than the QMB limit, enroll using the following ACs:
- Aged = 018
 - Blind = 038
 - Disabled = 058
- 3. Patient Pay** Determine patient pay according to section M1480.400 below.
- 4. Notices & Re-applications** The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” 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**

\$1,750.00	7-1-08	
\$1,711.25	7-1-07	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,739.00	1-1-09	
\$2,610.00	1-1-08	
- D. Excess Shelter Standard**

\$525.00	7-1-08	
\$513.38	7-1-07	
- E. Utility Standard Deduction (Food Stamps)**

\$290	1 - 3 household members	10-1-08
\$365	4 or more household members	10-1-08
\$252	1 - 3 household members	10-1-07
\$317	4 or more household members	10-1-07

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

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

\$875 gross earned income
- 75 first \$75 per month
800 remainder
 $\div 2$
400 ½ remainder
 ± 75 first \$75 per month
\$475 which is > \$190

His personal needs allowance is calculated as follows:

\$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
 ± 17.50 guardianship fee (2% of \$875)
\$247.50 personal needs allowance

**2. Medicaid
CBC Waiver
Services and
PACE**

a. Basic Maintenance Allowance

Deduct the appropriate maintenance allowance for one person as follows:

- 1) For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, Day Support (DS) Waiver or PACE:

Prior to September 1, 2006, the personal maintenance allowance was equal to the monthly SSI payment limit for one person. Effective September 1, 2006, the personal maintenance deduction is equal to 165% of the monthly SSI payment limit for one person. The personal maintenance deduction is:

- January 1, 2008 through December 31, 2008: \$1,051
- January 1, 2009 through December 31, 2009: \$1,112.

Contact a Medical Assistance Program Consultant for the SSI amount in effect for years prior to 2008.

- 2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person (\$2,022).

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- the patient has a legally appointed guardian or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance For EDCD, DD, DS and MR Waivers

[EXAMPLE #19 was deleted]

For EDCD, DD, DS and MR Waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- a) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022) per month.
- b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the MR Waiver is employed 18 hours per week. He has gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

\$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
\$1,440.80	personal maintenance allowance

his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is an MI pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution (see below).

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

1. MI Pregnant Woman

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

2. Individual Age 21-64 Admitted to Ineligible Institution

a. Entitlement - applicants

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual in the MMIS, enter the begin date and the end date of coverage.

b. Cancel procedures for ongoing enrollees

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the *current* date (*date the worker enters the cancel transaction in MMIS*), using cancel reason code "008."

c. Notice

An Advance Notice of Proposed Action is not required. Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

**3. Spenddown
Enrollees**

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

**C. Ongoing Entitle-
ment 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.

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If the child does not meet the 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.

**6. Child Turns
Age 21**

When an enrollee who is enrolled as a child under age 21 attains age 21, determine from the case information if the enrollee meets a definition for another covered group, such as blind, disabled, or pregnant woman.

**7. IV-E FC & AA
& Special
Medical Needs
Children From
Another State**

For FC or AA children placed by another state's social services agency, verification of continued IV-E eligibility status or non-IV-E special medical needs status, current address, and TPL can be obtained from agency records, the parent or the other state.

**8. Breast and
Cervical
Cancer
Prevention and
Treatment Act
(BCCPTA)**

The BCCPTA Redetermination, form #032-03-653, is used to redetermine eligibility for the BCCPTA covered group. The renewal form is available online at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

**9. SSI and QSII
(1619(b))
Covered Group
Recipients**

For recipients enrolled in the SSI and QSII Medicaid covered groups, the ex parte renewal consists of verification of continued SSI or 1619(b) status by inquiring SOLQ-I or SVES.

If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a Medicaid Renewal, form #032-03-699, must be completed and necessary verifications obtained to allow the eligibility worker to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

**10. Hospice
Covered Group**

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services.

**D. Recipient Becomes
Institutionalized**

When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, eligibility as an institutionalized individual must be determined using the policies and procedures in chapter M14.

E. LTC

LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 available at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> for the annual renewal. The DMAS-122 must be updated at least every 12 months, even when there is no change in the patient pay.

Ongoing eligibility for LTC recipients enrolled in the Medicaid SSI covered group can be established through an ex parte renewal, i.e., SVES inquiry.

M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION

M1520.401 NOTICE REQUIREMENTS

A. Policy

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage. If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The Advance Notice of Proposed Action must inform the enrollee of the last day of Medicaid coverage.

The Advance Notice of Proposed Action is available on SPARK at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

B. Change Results in Adverse Action

1. Services Reduction

When information is secured that results in a reduction of Medicaid services to the enrollee or a reduction in the Medicaid payment for the enrollee's services (when the patient pay increases), the "Advance Notice of Proposed Action" must be sent to the enrollee at least 10 days plus one day for mail, before the adverse action is taken.

If the enrollee requests an appeal hearing before the effective date, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the enrollee, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS). If the enrollee requests an appeal hearing before the effective date of the action and the DMAS Appeals Division notifies the local agency that the enrollee's coverage must be reinstated during the appeal process, reinstate the enrollee's coverage in the MMIS. **Do not reinstate coverage until directed to do so by the DMAS Appeals Division.**

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

2. Adverse Action Resulting from Computer Matches

When adverse action is taken based on information provided by computer matches from any source, such as IEVS, the Virginia Employment Commission (VEC) or SAVE, notice must be mailed at least ten (10) days before the effective date of the action, excluding the date of mailing and the effective date.

3. Matches That Require Advance Notice

The following list indicates some of the computer match sources which require a ten (10) day advance notice *when, after the worker reviews the individual's eligibility in light of the match information, the enrollee is determined ineligible:*

<u>Match Source</u>	<u>Notification Period</u>
Internal Revenue Service (IRS) unearned income files	10 days
Beneficiary and Earnings Data Exchange (Bendex)	10 days
State Data Exchange (SDX)	10 days
Enumeration Verification System (SSN)	10 days
Systematic Alien Verification For Entitlements (SAVE)	10 days
Department of Motor Vehicles (DMV)	10 days
Virginia Employment Commission (VEC)	10 days
Benefit Exchange Earnings Record (BEERS)	10 days
<i>Public Assistance Reporting Information System (PARIS)</i>	<i>10 days</i>

C. Procedures

1. Action Appealed

Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Appeals Division will notify the local agency whether to continue coverage during the appeal. **Do not reinstate coverage until directed to do so by the DMAS Appeals Division.**

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

- 2. Death of Recipient** The eligibility worker must take the following action when it is determined that an enrollee is deceased:
- If the enrollee has an SSN, the worker must verify the date of death. If the individual receives Social Security (Title II) payments or Supplemental Security Income, SOLQ-I can be used to verify the date of death. If the recipient does not receive these benefits but has an SSN, the worker must run a SVES request to verify the date of death. SVES will display an “X” and the date of death in the “SSN VERIFICATION CODE” field on Screen 1.
 - If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.
 - The worker must document the case file. Send adequate notice of cancellation to the estate of the enrollee at the enrollee’s last known address and to any authorized representative(s) using the “Notice of Action on Medicaid.”
 - Cancel coverage in MMIS using cancel code “001.” The effective date of cancellation is the date of death. Enter the date of death on the enrollee’s demographics screen under data field “DOD.”
- **End of Spenddown Period** When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

A. Introduction

- 1. MMIS Transaction** An enrollee’s coverage must be canceled in MMIS prior to the date of the proposed action. The change to the MMIS enrollee file must be made after system cut-off in the month the proposed action is to become effective. For example, if the Notice of Action specifies the intent to cancel coverage on October 31, a change to *MMIS* is made prior to cut-off in October.
- In the event the proposed action is not taken, the enrollee’s coverage must be immediately reinstated. If the enrollee files an appeal prior to the proposed date of action, the DMAS Appeals Division will notify the agency if the enrollee’s coverage should be reinstated.

**2. Reason "012"
Cancellations**

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the NOA. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

Cancel actions done by DMAS staff or MMIS are reported in the Client Information Document (CID) report available on SPARK at:
<https://securelocal.dss.virginia.gov/reports/benefits/vammis/index.cgi>.

M1520.403 ENROLLEE REQUESTS CANCELLATION

A. Introduction

An enrollee may request cancellation of his *and/or his children's medical assistance* coverage at any time. *The request can be verbal or written.*

B. Written Request

A written withdrawal request must be placed in the case record.

C. Verbal Request

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

D. Worker Action

When the enrollee requests cancellation of Medicaid, the local department must send a **Notice of Action** to the enrollee no later than the effective date of cancellation. Advance notice is not required when the enrollee requests cancellation.

**E. Notice
Requirements**

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

Cancel Medicaid coverage in MMIS using the cancel reason *code* "004."

Medicaid coverage will terminate if the child(ren) in the family turns age 18, or turns age 19 if the child is in school. *Use the Notice of Extended Medicaid Coverage form that is posted on SPARK at:*

<http://spark.dss.virginia.gov/divisions/bp/files/me/forms/general/032-03-0728-04-eng.doc>.

a. Instructions to Family

The family unit must be instructed to retain verifications of all earnings received during each month of the extension and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period. The names of the three months in the three-month period must be written out on the notice form and the *earnings* report form.

b. Notices

The instructions to the family are on the Notice of Extended Medicaid Coverage and on the second page of the notice which is the Medicaid Extension Earnings Report. The 2-page form is posted on SPARK at:

<http://spark.dss.virginia.gov/divisions/bp/files/me/forms/general/032-03-0728-04-eng.doc>.

c. MMIS Data Entry

After the worker sends the initial Extended Medicaid notice, the worker enters a Follow-up Code and Follow-up Date (the begin date of the extension) on the Case Data screen in MMIS. MMIS will automatically generate subsequent notices and earnings reports to the family. The MMIS Extended Medicaid procedures are contained in Chapter I of the MMIS Users' Guide for DSS.

2. Third Month of Extension

In the third month of extension, the unit must be notified that it must return the Medicaid Extension Earnings Report, with the earnings verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be sent automatically by *MMIS* if the correct Follow-up Code and effective date of the 12-month extension are entered on the *Case Data screen in MMIS*. If the *Follow-up Code* and *Follow-up Date* are **not** entered correctly or in a timely manner, the agency must manually send the notice.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period.

a. Notice Requirements

MMIS will send the advance notice and automatically cancel coverage at the end of the sixth month if the initial Follow-up Code and Date were entered correctly, and the code is **not** updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the *Advance Notice of Proposed Action* and must cancel the family's coverage in *MMIS* after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

b. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category **before the cut-off date** of the sixth extension month. If not eligible, leave the child's enrollment (the case Follow-up Code and Follow-up Date fields) as it is and *MMIS* will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the sixth extension month, *MMIS* will cancel coverage. The agency must reopen the child(ren)'s Medicaid if the child(ren) is determined eligible and must notify the recipient of the reopened coverage.

c. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. The Follow-up Code must be changed *on the MMIS Case Data screen* when the report is received in order for *Extended* Medicaid to continue. No action is taken on the first three-month period's earnings.

4. Sixth Month of Extension

In the sixth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month), with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

MMIS will automatically send this notice if the Follow-up Code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

If the second three-month period's report and verifications are not received by the 21st of the seventh month, the family's Medicaid coverage must be canceled after an Advance Notice of Proposed Action is sent. *MMIS* will send the advance notice and automatically cancel coverage if the report is not received on time and the code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

- illness or injury of family member(s) who is capable of obtaining and sending the material;
- agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month. If not eligible, leave the child's enrollment (the base case Follow-up Code and Follow-up Date fields) as it is and *MMIS* will cancel the child's coverage.

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

b. Cancellation Effective Date

Cancellation is effective the last of the eighth month of extension.

c. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, change the case Follow-up Code in *MMIS* immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

- 1) no child under age 18, or under age 19 if in school, lives with the family;
- 2) the family disenrolls from a group health plan that DMAS has determined cost-effective or fails to pay the premium to maintain the group health plan;
- 3) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
 - the caretaker/relative's involuntary lay-off,
 - the business closed,
 - the caretaker/relative's illness or injury,
 - other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work);

- 4) the family unit's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% *Federal Poverty Level (FPL)* appropriate to the family unit size.

See subchapter M0710, Appendix 7, for the 185% *FPL* income limits.

d. Calculate Family's Gross Earned Income

- 1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards. All earned income must be counted, including students' earned income, JTPA earned income, children's earned income, etc. No *exclusions or* disregards are allowed.
- 1) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.
- 2) To calculate average gross monthly income:
 - add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month *period's* cost of child care necessary for the caretaker/relative's employment.
 - add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
 - subtract the three-month *period's* cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
 - divide the remainder by 3; the result is the average monthly earned income.
 - compare the average monthly earned income to the monthly 185% *FPL* for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

- 1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member's eligibility for Medicaid in another covered group must be determined before canceling coverage.

Contact the recipient and request current verification of the family's total income, including earned and unearned income. If eligible, change the enrollment to the appropriate aid category before cut-off in the eighth extension month.

- 2) If the family is ineligible because of excess income, cancel Medicaid coverage. If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.
- 3) If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS, and transfer the case to the FAMIS Central Processing Unit (CPU).

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for *Extended Medicaid*, no action is required until the ninth month of extension, except to be sure that the Follow-up Code was updated in the computer when the income report was received.

6. Ninth Month of Extension

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

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

MMIS will automatically send this notice if the correct *Follow-up* Code is in the base case information on the computer. If it is not *correct*, the local agency must manually send this notice.

7. Tenth Month of Extension

If the third three-month period's report and verifications are not received by the 21st of the tenth month, the family's Medicaid coverage must be canceled after an advance notice is sent. *MMIS* will automatically cancel coverage and send the advance notice if the report is not received on time and the Follow-up Code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report timely (see 5. above for good cause).

a. Determine Child(ren)'s Eligibility

If the report is not received on time, the child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income. If eligible, change the child(ren)'s enrollment to the appropriate aid category before the **cut-off date** of the eleventh extension month. If not eligible, leave the child's enrollment (the base case Follow-up Code and Follow-up Date fields) as it is and *MMIS* will cancel the child(ren)'s coverage.

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

b. Cancellation Effective Date

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

c. Report Received Timely

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

d. Family No Longer Entitled To Extended Medicaid

- 1) If the family is not entitled to **extended** Medicaid coverage, review their eligibility for Medicaid in another category or for FAMIS or FAMIS MOMS. If not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension.
- 2) If the family is ineligible because of excess income, cancel Medicaid coverage. **Send the Advance Notice of Proposed Action**. If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.
- 3) If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS and transfer the case to the FAMIS Central Processing Unit (CPU).

e. Family Remains Entitled To Extended Medicaid

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

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination. *MMIS* will automatically cancel coverage and send the advance notice after cut-off of the twelfth month, if the Follow-up Code was updated correctly. Therefore, for any of the family members that remain eligible for Medicaid or FAMIS-FAMIS MOMS, the AC and the Follow-up Code must be changed before cut-off of the twelfth month.

If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS and transfer the case to the FAMIS Central Processing Unit (CPU).

For family members who are not eligible for Medicaid or FAMIS-FAMIS MOMS, **send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month.

If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

M1520.600 CASE TRANSFERS

- A. Introduction** Applications and ongoing cases are transferred only when the individual retains residence in Virginia.
- B. Nursing Facility and Assisted Living Facility (ALF)** When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.
- When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.
- C. DMHMRSAS Facilities** The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from DMHMRSAS facilities are in subchapter M1550. F&C cases are not transferred *to the DMHMRSAS facilities*.
- D. Cases From DMAS FAMIS Plus Unit FIPS 976** The Medicaid cases approved by the DMAS FAMIS Plus Unit, FIPS 976, must be transferred to the local *department of social services (LDSS)* where the recipient lives. Medicaid cases are **not** transferred from local agencies **to the DMAS FAMIS Plus Unit (FIPS 976)**.
- 1. Confirm Receipt** The receiving *LDSS* must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the DMAS FAMIS Plus Unit.
 - 2. Review Eligibility** *LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from the DMAS FAMIS Plus Unit and must take any necessary corrective action.*
 - 3. Corrective Action** *If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back to the DMAS FAMIS Plus Unit. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the DMAS FAMIS Plus Unit supervisor.*
 - 4. Eligible for FAMIS or FAMIS MOMS** *If the LDSS re-evaluation of the case's Medicaid eligibility results in Medicaid ineligibility, but some or all case members are eligible for FAMIS or FAMIS MOMS, follow the case transfer procedures in Chapter M2140 E.*

**E. Cases From
Outstationed Workers**

*Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) or the workers at Medical College of Virginia (MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS to outstationed workers.*

1. Confirm Receipt

The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.

2. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.

3. Corrective Action

If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.

**F. Local Agency to
Local Agency**

When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:

**1. Sending Locality
Responsibilities****a. Case Renewal Cannot Be Overdue**

The sending locality must make certain the case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed *before transferring the case*.

If the annual renewal is due in the month the LDSS plans to transfer the case or the following month, the renewal must be completed before transferring the case.

Exception: *When the Medicaid case is in ADAPT and Food Stamps is active in the ADAPT case, the Food Stamps case transfer rules override the Medicaid policy that the Medicaid renewal cannot be overdue. The ADAPT case must be transferred immediately to the new locality, even if the Medicaid renewal is overdue, due in the transfer month or due in the following month to comply with the Food Stamps case transfer rule.*

b. When Renewal Must Be Completed Before Transferring

If the sending LDSS must complete the renewal before transferring the case, the Sending LDSS must keep the case record to complete the renewal.

The sending locality must update the enrollees' MMIS records as follows to assure managed care continuity:

- 1) *Case Data screen - change the case address to the case's new address. Do not change the Case FIPS or Caseworker number because the sending LDSS worker retains responsibility for the case until the renewal is completed.*
- 2) *Enrollee Demographics screen, Enrollee FIPS – change each enrollee's Enrollee FIPS to the new address's FIPS code.*

When the renewal is completed and the enrollee remains eligible, transfer the ADAPT case (if in ADAPT) or update the enrollee's MMIS Case FIPS to the enrollee's locality of residence and update the Caseworker number to M0000. Send the paper case record to the enrollee's locality of residence with a completed Case Record Transfer Form.

c. Do Not Transfer Ineligible Cases

If the annual renewal or the partial review finds that eligibility no longer exists *for one or all enrollees in the case*, the agency must take the necessary action, including advance notice to the individuals, to cancel the *ineligible individuals' coverage*. *Only eligible enrollees' cases are transferred.*

d. Transfer Eligible Enrollees/Cases

If the renewal or the partial review indicates that the *enrollee(s)* will continue to be eligible for Medicaid in the new locality, the sending locality must update the *ADAPT case, if the case is in ADAPT, or MMIS if the case is not in ADAPT*. The sending locality must prepare the "Case Record Transfer Form" and forward it with the case record to the *LDSS* in the new locality of residence.

e. Transfer Pending Medicaid Applications

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

f. Foster Care & Adoption Assistance

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

g. Sending Transferred Cases

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

**2. Receiving
Locality
Responsibilities**

a. Confirm Receipt

The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

b. Process Pending Applications

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

c. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from other LDSS and must take any necessary corrective action.

d. Corrective Action

If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the sending agency's supervisor.

G. Spenddown Cases

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

1. Sending Locality Responsibilities

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

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

2. Receiving Locality Responsibilities

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

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

**DMHMRSAS Facilities
Medicaid Technicians**

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Brenda Wolfhert, Supervisor (T006)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-2754 cell 434-906-0024	CVTC-caseload-A-H
Mary Lou Spiggle (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-6256	CVTC-caseload-I-Z PGH-caseload-all WSH-caseload-all NVMHI-caseload-all SVMHI-caseload-all
Debra J. Quesenberry (T002)	Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070	540-375-4350	Catawba-caseload-all NVTC-caseload-all <i>Hiram Davis-caseload-all</i>
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841	SWVTC-caseload-all ESH-caseload-A-J SSVTC-A-L
Terri Neel-Kinder (T005)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842	SEVTC-caseload-all ESH-caseload-K-Z SWVMHI-caseload-all SSVTC-M-Z

NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DMHMRSAS Facilities:

FIPS	Facility Initials and Full Name
997	Catawba – Catawba Hospital
990	CVTC – Central Virginia Training Center
994	ESH – Eastern State Hospital
988	NVMHI – Northern Virginia Mental Health Institute
986	NVTC – Northern Virginia Training Center
993	PGH – Piedmont Geriatric Hospital
985	SEVTC – Southeastern Virginia Training Center
989	SSVTC – Southside Virginia Training Center
983	SVMHI – Southern Virginia Mental Health Institute
992	SWVMHI – Southwestern Virginia Mental Health Institute
984	SWVTC – Southwestern Virginia Training Center
991	WSH – Western State Hospital
996	<i>Hiram Davis Medical Center</i>

**E. Extra Help
Policy Principles**

Extra Help provides assistance with the out-of-pocket costs associated with Medicare Part D. An individual is eligible for Extra Help if all of the following are met:

- he is a resident of the United States,
- he is entitled to Medicare Part A and/or enrolled in Medicare Part B,
- he and his spouse, if married and living together, have countable income less than 150% of the federal poverty level (FPL) for his assistance unit size,
- he has countable resources of no more than \$11,010 (or if he is married and living with a spouse, they have countable resources of no more than \$22,010, and
- he must reside in the service area of a Part D prescription drug plan (service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia, and U.S. Territories).

M2020.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The nonfinancial eligibility requirements for Extra Help are different than the nonfinancial requirements for the Medicare Savings Programs (see chapter M02). An individual who does not meet the nonfinancial requirements for the Medicare Savings Programs may meet the nonfinancial requirements for Extra Help.

**B. Extra Help
Nonfinancial
Requirements**

Only the following nonfinancial eligibility requirements apply when Extra Help eligibility is determined by the LDSS:

- residency in Virginia, and
- entitlement to Medicare. The individual does not need to be enrolled in Medicare at the time of application, but Extra Help will not begin until he has enrolled in Medicare Part D.

M2030.100 DETERMINING EXTRA HELP SUBSIDY ELIGIBILITY

A. Introduction

In the event that an applicant requests an Extra Help determination by the LDSS, the LDSS must comply with the request. Unless the applicant is later found to be deemed eligible for Extra Help or has been found eligible by SSA, the LDSS will also be responsible for ongoing case activity, including notices, appeals, and redeterminations.

B. Applicant's Representative

The applicant may be represented by any of the following individuals:

- an individual who is authorized to act on behalf of the applicant;
- if the applicant is incapacitated or incompetent, someone acting responsibly on his or her behalf; or
- an individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process;

Anyone may help the individual apply for the subsidy. The person assisting the applicant is required to attest to the accuracy of the information on the application.

C. Interview

A face-to-face interview is not required for Extra Help.

D. Screening for Deemed Status

LDSS must conduct its usual screening process to determine if the applicant is enrolled in Medicaid (full benefit or the limited benefit QMB, SLMB, or QI) or receives SSI. If the applicant is found to be in one of these programs, the applicant is deemed eligible for the subsidy and no application is required. M20, Appendix 1, Screening Script for Help with Medicare Costs (Form #032-03-701) and M20, Appendix 2, Screening Worksheet for Help with Medicare Costs (Form #032-03-702) are suggested screening tools.

E. Clearances

Eligibility workers should conduct their usual SDX/SVES/SOLQ clearances to verify the applicant's entitlement/enrollment in Medicare Parts A and B. If no Medicare entitlement/enrollment can be confirmed, deny the Extra Help application. If the available data confirm Medicare Buy-In in another U.S. jurisdiction, the applicant has already been deemed eligible for the subsidy. The LDSS must inform the applicant's former state of the change of address, and offer a Medicaid application to the applicant explaining that if he qualifies for Medicaid in Virginia, he automatically qualifies for Extra Help.

F. Spenddown

If the applicant is on a Medicaid spenddown in the month of application for the subsidy, continue with the Extra Help determination, using monthly countable income. If the applicant meets Medicaid eligibility during the month of subsidy application, he is deemed eligible for Extra Help. Once deemed eligible, the individual will receive the subsidy for the remainder of the calendar year.

G. Family Size

For the purpose of establishing the applicable income limit only, the following persons are counted in the family size:

- the applicant;
- the applicant's spouse, if living together; and
- any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support. Accept the applicant's statement that he has a dependent.

M2040.100 FINANCIAL REQUIREMENTS

A. Introduction

Modified Supplemental Security Income (SSI) regulations are used to evaluate income and resources for Extra Help. For certain sections, the worker is referred to the on-line Program Operations Manual System (POMS) at <http://policy.ssa.gov/poms.nsf/aboutpoms> for more information. All types of countable income and resources must be verified.

The intent of the MMA was that the state and SSA determinations would be identical given the same information about the applicant/spouse. The guidance in this chapter and POMS must be used to determine eligibility for Extra Help.

M2040.200 RESOURCE REQUIREMENTS

A. Evaluating Resources

Resources of the applicant and his spouse if living together, but not resources of dependent family members are used to determine resource eligibility.

Count liquid resources which are cash or can be converted to cash within 20 days, including but not limited to:

- stocks;
- bonds;
- mutual fund shares;
- promissory notes (including mortgages held by the applicant);
- whole life insurance policies;

- financial institution accounts, including:
 - savings and checking accounts; and
 - time deposits, also known as certificates of deposit;
 - individual Retirement Accounts (IRAs) and
 - 401(K) accounts; and
- the equity value of real property not contiguous with home property (see M2040.200.E).

B. Resource Standards

The maximum subsidy resource standards are \$11,010 for one person and \$22,010 for a married couple. Resources at or below \$6,600 for an individual and \$9,910 for a married couple and income at or below 135% FPL entitles the applicant(s) to the full subsidy.

The SSA subsidy application (SSA-1020) lists *the resource limits* to reflect the burial fund exclusion of \$1500 for one person and \$3000 for a couple. These amounts apply **only** if the applicant/spouse indicates intent to use resources for burial or funeral arrangements. If the applicant/spouse has no intent to use resources for burial or funeral arrangements, *do not give the burial fund exclusion.*

C. Resource Exclusions

The following resources are not to be considered for purposes of determining Extra Help eligibility:

- the applicant's home. For the purposes of this exclusion, a home is any property in which the applicant and his spouse have an ownership interest and which serves as his principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings;
- non-liquid resources, other than real property. These include, but are not limited to
 - household goods and personal effects;
 - automobiles, trucks, tractors and other vehicles;
 - machinery and livestock;
 - noncash business property;
- property of a trade or business which is essential to the applicant/spouse's means of self-support;
- nonbusiness property which is essential to the applicant/spouse's means of self-support;

- application date;
- description of how the subsidy was calculated; what income, family size, and resources were used;
- premium percentage;
- effective date of eligibility;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- a reminder to apply for a prescription drug plan.

M20, Appendix 5 contains the Notice of Approval on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-703).

C. Denial Notice

When the LDSS denies an application for Extra Help, a denial notice must be sent and must include the following information:

- application date;
- reason for denial and policy citation;
 - not Medicare-eligible;
 - failure to complete the application process;
 - income is equal to or exceeds 150% FPL;
 - resources exceed \$11,010/\$22,010;
 - not a resident of the State;
 - not a resident of U.S./incarcerated;
- description of how the denial was calculated; what income, family size, and resources were used;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the denial reason, a reminder to apply for a prescription drug plan.

M20, Appendix 6 contains the Notice of Denial on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-704).

D. Termination Notice

When the LDSS determines an individual is no longer eligible for Extra Help, a termination notice must be sent and must include the following information:

- reason for termination and policy citation;
 - not Medicare-eligible;
 - failure to complete the redetermination process;
 - income is equal to or exceeds 150% FPL;
 - resources exceed \$11,010/\$22,010;
 - not a resident of the State;
 - not a resident of U.S./incarcerated.

- description of how the termination was calculated; what income, family size, and resources were used;
- effective date of termination;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the termination reason, a reminder that he can still use his prescription drug plan.

M20, Appendix 7 contains the Notice of Termination of Your Extra Help with Medicare Part D Costs (Form #032-03-705).

E. Change Notice

When the LDSS determines that an individual's eligibility for Extra Help has changed, it is required to send a change notice containing the following information:

- reason for change in subsidy level and policy citation;
- new premium percentage;
- description of how the change was calculated; what income, family size, and resources were used;
- effective date of change;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- reminder that he can still use his prescription drug plan but that his costs within the plan have changed.

M20, Appendix 8 contains the Notice of Change in the Amount of Extra Help with Medicare Part D Costs (Form #032-03-706).

All notices must meet the adequate and timely notice requirements of the Medicaid State Plan.

M2070.100 APPEALS AND FAIR HEARINGS

A. Decision made by LDSS

The applicant may appeal his Extra Help determination according to the appeal procedures found in chapter M16. The individual has 30 days from the receipt of the notice to file an appeal.

B. Decision made by SSA

SSA will be responsible for appeals of decisions made by SSA, including decisions made on SSA applications forwarded to SSA by the State.

Screening Script for Help with Medicare Costs

“This is a preliminary, voluntary screening to see if you might be eligible for programs that help pay Medicare expenses. It is not an application for these programs. The information you provide will assist us in determining if you may be eligible for these programs.

Do you have Medicare Part A or Part B Yes _____ No _____

Are you: (1) single or married but not living with your spouse? _____ Go to A. below

or

(2) married and living with your spouse? _____ Go to B. below

A. Single or Not Living with Spouse

“Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions.”

Is your monthly income before any deductions less than \$1,353.75 per month? Yes _____ No _____

“Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources.”

Do you have less than \$11,010 in resources? Yes _____ No _____

B. Married and Living with Spouse

“Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions.”

Is your combined monthly income before any deductions less than \$1,821.25 per month? Yes _____ No _____

“Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources.”

Do you and your spouse have less than \$22,010 in resources? Yes _____ No _____

“Based on this screening, it appears that you (choose one) may / may not be eligible for Extra Help with your Medicare Part D costs. You may apply for Extra Help directly at the Social Security Administration office or by calling 1-800-772-1214. You may apply even if it appears that you may not be eligible. Your income and resources can be verified by the Social Security Administration.”

“If your income is less than \$1,219 for one person or \$1,640 for a couple and your resources are less than \$4,000 for one person or \$6,000 for a couple, you may want to apply for Medicaid. If you are found eligible, Medicaid will cover some or all of your Medicare expenses, and you will automatically be eligible for Extra Help with your Medicare Part D costs .”

Screening Worksheet for Help with Medicare Costs

- I. Do you have Medicare Part A or Part B Yes _____ No _____
- II. Marital status:
Is person single? Yes _____ No _____
Or married and living with spouse? Yes _____ No _____
(Count income and resources of a couple who are married and living together).
- III. Income:
a. Total monthly earned income: _____
b. Minus \$65 and ½ : _____ = countable earned
c. Total monthly unearned income _____
d. Minus \$20 _____ = countable unearned
- Total countable income (add lines b. and d.): _____
- IV. Total countable resources: _____
- V. Dependents: Does the individual/couple live with any relatives for whom he/she provides at least 1/2 of their financial support? Yes _____ How Many? _____ No _____
- VI. Screen:

Countable Limits	MSP Eligible		Extra Help Eligible			
	1	2	1	2	3	4
Income	\$1,219	\$1,640	< \$1,353.75	< \$1,821.25	< \$2,288.75	< \$2,756.25
Resources	\$4,000	\$6,000	\$11,010	\$22,010 (C)	\$11,010 (S) \$22,010 (C)	\$11,010 (S) \$21,010 (C)

S = Single C = Married Couple

If income is less than or equal to 135% and resources do not exceed MSP limits, the individual may be eligible for Medicaid. A Medicaid application must be completed and all information must be verified.

If income is greater than 135% and/or resources do not exceed the Extra Help limits, offer to assist the individual with applying for Extra Help from the Social Security Administration.

EXTRA HELP INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/23/09 MONTHLY GUIDELINES					
FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	<i>\$902.50</i>	<i>\$1,218.38</i>	<i>\$1,263.50</i>	<i>\$1,308.63</i>	<i>\$1,353.75</i>
2	<i>1,214.17</i>	<i>1,639.13</i>	<i>1,699.83</i>	<i>1,760.54</i>	<i>1,821.25</i>
3	<i>1,525.83</i>	<i>2,059.88</i>	<i>2,136.17</i>	<i>2,212.46</i>	<i>2,288.75</i>
4	<i>1,837.50</i>	<i>2,480.63</i>	<i>2,572.50</i>	<i>2,664.38</i>	<i>2,756.25</i>
5	<i>2,149.17</i>	<i>2,901.38</i>	<i>3,008.83</i>	<i>3,116.29</i>	<i>3,223.75</i>
6	<i>2,460.83</i>	<i>3,322.13</i>	<i>3,445.17</i>	<i>3,568.21</i>	<i>3,691.25</i>
7	<i>2,772.50</i>	<i>3,742.88</i>	<i>3,881.50</i>	<i>4,020.13</i>	<i>4,158.75</i>
8	<i>3,084.17</i>	<i>4,163.63</i>	<i>4,317.83</i>	<i>4,472.04</i>	<i>4,626.25</i>

For family units of more than 8 members, contact a Medical Assistance Program Consultant.

MAXIMUM VALUE OF CONTRIBUTED FOOD AND SHELTER

SINGLE/COUPLE	MONTHLY AMOUNT
SINGLE	\$224.66
COUPLE	337.00

CALCULATION TABLES

Subsidy Calculation for One Person

Countable Resources in \$	≤135% FPL	> 135% to ≤140% FPL	> 140% to ≤ 145% FPL	> 145% to < 150% FPL	≥ 150%
≤ \$6,600	A	C	D	E	F
> \$6,600 to ≤ \$11,010	B	C	D	E	F
> \$11,010	F	F	F	F	F

Subsidy Calculation for a Couple

Countable Resources in \$	< 135% FPL	> 135% to ≤ 140% FPL	> 140% to ≤ 145% FPL	> 145% to < 150%	≥ 150%
≤ \$9,910	A	C	D	E	F
> \$9,910 to ≤ \$22,010	B	C	D	E	F
> \$22,010	F	F	F	F	F

Subsidy Benefits

Subsidy	Subsidized Monthly Premium	Yearly Deductible	Pre-Catastrophic Co-pay per Prescription	Coverage Gap? Y/N	Catastrophic Co-pay per Prescription
A	100%	\$0	\$2.40/\$6.00	N	\$0
B	100%	\$60	15%	N	\$2.40/\$6.00
C	75%	\$60	15%	N	\$2.40/\$6.00
D	50%	\$60	15%	N	\$2.40/\$6.00
E	25%	\$60	15%	N	\$2.40/\$6.00
F (No subsidy)	0%	\$295	25%	Y	@5%

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

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

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

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

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

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

Case management and ongoing case maintenance, and selection for managed care, are handled by the FAMIS CPU.

B. Legal Base

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

C. Policy Principles

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

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

- he is **not** eligible for FAMIS Plus *and he has income in excess of the FAMIS Plus limits*;
- he is under age 19 and a resident of Virginia;

- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 2 to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

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

B. M02 Requirements

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

- citizenship and alienage requirements, including Afghan and Iraqi special immigrants in M0220.313 A, with the exceptions noted in M2120.100 C.1. below;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. *Citizenship & Identity Verification NOT Required*

The child must meet the United States (US) citizenship requirements in M0220.001. Verification is not required; declaration of the child's US citizenship is accepted. The citizenship and identity verification requirements in M0220.100 do NOT apply to FAMIS. If not a US citizen, the child must meet the alienage requirements.

2. **Alienage Requirements**

Alien status must be verified. Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

- a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:
 - refugees or Cuban-Haitian Entrants (see M0220.310 A. 2 and 7),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A.52).
- b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States**:
 - lawful permanent residents (LPR),
 - conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
 - aliens, other than Cuban-Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
 - battered aliens, alien parents of battered children, alien children of battered parents.

3. **No Grandfathered Aliens** The Medicaid policy for grandfathered aliens under age 19 does NOT apply to FAMIS.
4. **No Emergency Services Only For Unqualified Aliens** Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements and are not eligible for FAMIS.
5. **Alien Eligibility Chart** Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.
6. **SSN** A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.
7. **Assignment of Rights** Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

- 8. HIPP** Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to FAMIS.
- D. FAMIS Nonfinancial Requirements** The child must meet the following FAMIS nonfinancial requirements:
- 1. Age Requirement** The child must be under age 19 for at least one day during the month. No verification is required.
- A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.
- 2. Uninsured Child** The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.
- 3. State Employee Prohibition** A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.
- 4. IMD Prohibition** The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

- A. Introduction** The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, or the child is pregnant.
- B. Definitions**
- 1. Creditable Coverage** For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:
- church plans and governmental plans;
 - health insurance coverage, either group or individual insurance;
 - military-sponsored health care;
 - a state health benefits risk pool;
 - the federal Employees Health Benefits Plan;
 - a public health plan; and

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/23/09				
# of Persons in FAMIS Assistance Unit	FAMIS 150% FPL		FAMIS 200% FPL	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	<i>\$16,245</i>	<i>\$1,354</i>	<i>\$21,660</i>	<i>\$1,805</i>
2	<i>21,855</i>	<i>1,822</i>	<i>29,140</i>	<i>2,429</i>
3	<i>27,465</i>	<i>2,289</i>	<i>36,620</i>	<i>3,052</i>
4	<i>33,075</i>	<i>2,757</i>	<i>44,100</i>	<i>3,675</i>
5	<i>38,685</i>	<i>3,224</i>	<i>51,580</i>	<i>4,299</i>
6	<i>44,295</i>	<i>3,692</i>	<i>59,060</i>	<i>4,922</i>
7	<i>49,905</i>	<i>4,159</i>	<i>66,540</i>	<i>5,545</i>
8	<i>55,515</i>	<i>4,627</i>	<i>74,020</i>	<i>6,169</i>
Each additional, add	<i>5,610</i>	<i>468</i>	<i>7,480</i>	<i>624</i>

M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 185% of the federal poverty level (FPL). An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

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

Initial eligibility for FAMIS MOMS is determined by local departments of social services (LDSS), including LDSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Case management and ongoing case maintenance, and selections for managed care, are handled by the FAMIS CPU.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 185% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- she is a resident of Virginia;
- she is uninsured;
- she is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 3 to Chapter M21 for a list of state agencies);
- she is not an inmate of a public institution;

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 185% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. Policy** The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.
- B. M02 Applicable Requirements** The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:
- *citizenship or alien status;*
 - Virginia residency requirements;
 - assignment of rights;
 - application for other benefits;
 - institutional status requirements regarding inmates of a public institution.
- C. FAMIS Nonfinancial Requirements** The FAMIS nonfinancial eligibility requirements are:
- 1. Citizenship & Identity Verification NOT Required** *The pregnant woman must meet the United States (US) citizenship requirements in M0220.001. Verification is not required; declaration of the woman's US citizenship is accepted. The citizenship and identity verification requirements in M0220.100 do NOT apply to FAMIS MOMS. If not a US citizen, the pregnant woman must meet the alienage requirements.*
- 2. Alienage Requirements** FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.
- a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.
 - b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **without any time limitations**:
 - refugees (see M0220.310 A. 2),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A.52).

- c. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States:**
- lawful permanent residents (LPRs),
 - conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
 - aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
 - battered aliens, alien parents of battered children, alien children of battered parents.
- d. Afghan and Iraqi special immigrants who meet all other eligibility requirements for FAMIS MOMS are eligible for a limited period of time from the date they enter the U.S. or the date their immigrant status is converted to Special Immigrant Visa (SIV) status. See section M0220.313 A and Appendix 3 to Chapter M21 for the limited time periods and details about these special immigrants. When the limited time period (6 or 8 months, beginning with the month of entry or status conversion to SIV) is over, these special immigrants are no longer eligible for FAMIS MOMS because of their lawful permanent resident (LPR) status. LPRs are not eligible for FAMIS MOMS for the first 5 years they reside in the U.S.
- e. Appendix 3 to Chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.

3. No Emergency Services for Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens.

4. SSN not Required

The applicant is not required to provide an SSN or proof of an application for an SSN.

5. HIPP not Applicable

Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do NOT apply to FAMIS.

D. FAMIS MOMS Covered Group Requirements

1. Verification of Pregnancy

Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, public health nurse or similar medical practitioner. Documentation of how the pregnancy was verified must be included in the case record.

2. **Must be Uninsured** The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.
3. **IMD Prohibition** The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).
4. **State Employee Health Benefits Prohibition** A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage.

See Appendix 2 to Chapter M21 for a list of state government agencies.

M2220.200 HEALTH INSURANCE COVERAGE

- A. **Introduction** The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.
- B. **Definitions**
 1. **Creditable Coverage** For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:
 - church plans and governmental plans;
 - health insurance coverage, either group or individual insurance;
 - military-sponsored health care;
 - a state health benefits risk pool;
 - the federal Employees Health Benefits Plan;
 - a public health plan; and
 - any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.
 2. **Employer-Sponsored Dependent Health Insurance** Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.
 3. **Family Member** ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, "family member" means the pregnant woman's spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. "Family member" includes the pregnant woman's stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee's unmarried **dependent** child or stepchild under age 23 years.

FAMIS MOMS INCOME LIMITS ALL LOCALITIES		
EFFECTIVE 01/23/09		
# of Persons in FAMIS MOMS Assistance Unit	FAMIS MOMS 185% FPL	
	Annual Limit	Monthly Limit
2	\$26,955	\$2,247
3	33,874	2,823
4	40,793	3,400
5	47,712	3,976
6	54,631	4,553
7	61,550	5,130
8	68,469	5,706
Each additional, add	6,919	577