



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

March 1, 2011

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #95

The following acronyms are used in this transmittal:

- ABD – Aged, Blind or Disabled
- ADAPT – Application/Benefit Delivery Automation Project
- BCCEDP – Breast and Cervical Cancer Early Detection Program
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- DC – District of Columbia
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- LDSS – Local Departments of Social Services
- LTC – Long-term Care
- MI – Medically Indigent
- MSP – Medicare Savings Program
- PACE – Program of All-inclusive Care for the Elderly
- QI – Qualified Individual
- QMB – Qualified Medicare Beneficiaries
- SAVE – Systematic Alien Verification for Entitlements
- SLMB – Special Low Income Medicare Beneficiaries
- SPARK – Services Programs Answers Resources Knowledge
- SSA - Social Security Administration
- SSI – Supplemental Security Income
- TPL – Third Party Liability
- U.S. – United States
- USCIS - United States Citizenship and Immigration Services
- VDSS – Virginia Department of Social Services
- VIEW – Virginia Initiative for Employment Not Welfare

This transmittal includes new, revised, clarified and updated Medicaid eligibility policy and procedures effective on March 1, 2011, unless another date is indicated for the revision.

New Policy

The immigration status for all immigrants applying for public assistance must be verified through the SAVE system. This transmittal includes policy on a new notice requirement for immigrant applicants mandated by the USCIS. All applicants for benefits who are denied benefits based solely or in part on the SAVE response must be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The USCIS fact sheet, "Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS" (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, including the approval of emergency-services-only Medicaid coverage, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. This policy was posted in Broadcast 6522.

This transmittal also contains new policy regarding access to breast and cervical cancer screenings under the BCCEDP. Women who live in the Northern Virginia area (Cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are now allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's Project Wish program. Women who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the non-financial eligibility requirements contained in M0320.312 of the Medicaid Eligibility Manual and do not have creditable health insurance. These women will receive a Virginia BCCPTA application form from the DC providers and will be instructed to apply for Medicaid at the local department of social services in their home locality.

Effective January 1, 2011, the Medicaid LTC home equity limit will be subject to change annually. This marks the first time the limit has increased since the implementation of the home equity requirement in January, 2006. For 2011, the limit was increased from \$500,000 to \$506,000.

Policy regarding verification of the termination of TPL was added in this transmittal. When an individual reports that TPL coverage was cancelled, the eligibility worker must try to obtain written or verbal verification of the cancellation from the insurer. If verification cannot be obtained, the worker must make a referral to the DMAS TPL Unit regarding the case, which will follow up with the insurance company; however, the worker cannot end date the TPL without verification.

Information regarding the new administrative renewal process for FAMIS cases has been added to Chapter M21. Although the policy does not directly impact LDSS, it is important that LDSS staff are aware of the new process should they inadvertently receive renewal forms or inquires from parents of children enrolled in FAMIS.

Revised Policy

In subchapter M0220, USCIS forms and contact information have been subject to frequent change; therefore, several appendices containing this material were removed from M0220, and web links were added for USCIS forms and contact information. The remaining appendices in M0220 were reordered and renumbered for organizational clarity.

In subchapter M1450, the policy regarding when an asset transfer penalty period begins was revised for improved clarity. In subchapter M1520, the policy regarding how LDSS staff are to handle cases transferred from the FAMIS Plus Unit was revised.

Clarified Policy

The circumstances under which systems searches of client information are allowed were clarified. For non-applicants, workers may use systems searches for income and other information necessary to determine the applicant's eligibility when the non-applicant is a member of the assistance unit. The policy on who can apply was also clarified to indicate that parents are permitted to apply for children under age 21 when the child lives in the parent's household.

In M0220, the policy on refugees retaining their "seven-year" full benefit status after becoming permanent residents was clarified to include all groups of "seven-year" aliens. Also, policy was clarified regarding when a non-citizen's statement of intent to remain in the U.S. is acceptable.

In M0310 and 320, policy was clarified to indicate that children born to young women receiving Title IV-E Foster Care payments are also considered IV-E Foster Care children when the mother is receiving a supplemental payment for the child.

Policy was clarified that Medicare is considered creditable health insurance coverage for the Plan First, FAMIS, and FAMIS MOMS covered groups. Also, limited benefit health insurance and insurance under which benefits have been exhausted are still considered creditable health insurance coverage for the BCCPTA covered group.

Clarifications are also contained in this transmittal to policy regarding:

- the agency responsible for processing applications made by incarcerated individuals
- the use of the Citizenship and Identity Insert
- QI renewals
- the treatment of trial visits for foster care children
- the hierarchy of processing for an SSI recipient who does not meet the real property requirements
- the treatment of irrevocable burial arrangements as burial funds
- the definition of an old bill for the purposes of spenddown
- asset transfer, the resource assessment, and other LTC-related areas
- the treatment of income for S-corporations.

Updated Policy

This transmittal also contains updated Medicare premium amounts and MSP resource limits for 2011, as well as the LTC utility standard deduction effective October 1, 2010. The average monthly private nursing facility cost increased for 2011 and was updated. Again for 2011, the SSI-based income limits and standards, as well as the LTC spousal and maintenance standards based on the Consumer Price Index did not change. References to these standards and allowances have been revised in this transmittal to indicate that they are unchanged in 2011. Many of these figures were posted in Broadcast 6660.

The MI and Plan First income limits that are based on a percentage of the FPL are updated in this transmittal. These income limits were announced in Broadcast 6701 and were effective January 20, 2011.

Electronic Version

Transmittal #95 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the Transmittal of record. Significant changes to the manual are as follows:

| Pages Changed | Significant Changes |
|--|--|
| Subchapter M0110 page 2 | On page 2, clarified the circumstances under which systems searches of client information are allowed. |
| Subchapter M0120 pages 1, 8, 14 | On page 1, clarified that a parent can apply for a child under age 21 living with the parent. On page 8, clarified that enrollees do not need to reapply when they turn 18. On page 14, clarified that for incarcerated applicants who did not reside in Virginia prior to incarceration, the LDSS serving the locality in which the correctional facility is located is responsible for processing the application. |
| Subchapter M0130 page 8 | On page 8, clarified the circumstances under which systems searches of client information are allowed. |
| Subchapter M0220 pages 3, 4, 14a, 14b pages 17, 20, 24 Appendix 1, pages 1, 4, 5, 15 | <p>On page 3, clarified that the Citizenship and Identity Insert can be used to inform applicants of the requirements. On page 4, clarified that seven-year full-benefit aliens remain full-benefit aliens if they become Lawful Permanent Residents. On pages 14a, 14b and 17, clarified that seven-year full-benefit aliens remain full-benefit aliens if they become Lawful Permanent Residents. On page 20, clarified that a person cannot change his intent to remain in the U.S. retroactively. On page 24, added policy requiring a SAVE fact sheet to be sent to applicants denied Medicaid or approved for coverage of emergency services only due to information verified in SAVE.</p> <p>Appendices 1-2a were removed because the information is available online and changes frequently. The remaining appendices, except Appendix 4, were reordered and renumbered so that they correspond with the order in which they are referenced in the subchapter. On Appendix 1, pages 1, 4, 5 and 15, the policy on accepting birth certificates from individuals born in Puerto Rico was revised.</p> |
| Subchapter M0230 page 1 | On page 1, clarified that a person cannot change his intent to remain in the U.S. retroactively. |
| Subchapter M0310 pages 30, 30a | On page 30, clarified that a child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's Title IV-E payment includes an allocation for her child. On page 30a, clarified the policy on continued Medicaid eligibility during trial visits. |
| Subchapter M0320 pages 11, 12, 42c, 42d, pages 50, 53, 69, 70, 71 page 72 was added. | On pages 11 and 12, updated the Social Security and Medicare information for 2011. On pages 42c and 42d, revised the policy on renewals for the QI covered group. On page 50, clarified that Medicare Part B is considered creditable health insurance for the Plan First covered group. On page 53, clarified that a child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's Title IV-E payment includes an allocation for her child. On page 69, added policy regarding the availability of qualified BCCEDP screening centers in the District of Columbia for women in northern Virginia. On page 70, |

| Pages Changed | Significant Changes |
|--|--|
| | clarified that a woman is not eligible for Medicaid in the BCCPTA covered group even if her insurance does not cover her cancer treatment. Pages 71 and 72 are runover pages. |
| Subchapter M0530 page 1 Appendix 1, page 1 | On page 1, clarified the covered group hierarchy for an SSI recipient who does not meet the real property requirements for Virginia Medicaid. On Appendix 1, page 1, updated the deeming standards for 2011. |
| Subchapter M0710 Appendix 6, pages 1, 2 Appendix 7 | In Appendices 6 and 7, updated the income limits for MI children under 19, VIEW participants, MI pregnant women, Plan First and Extended Medicaid for 2011. |
| Subchapter M0810 pages 1, 2 | On pages 1 and 2, updated the SSI-based and ABD MI income limits for 2011. |
| Subchapter S0820 pages 3, 30, 31 | On page 3, added information about S-corporations. On pages 30 and 31, updated the blind or disabled student child earned income exclusion amount for 2011. |
| Subchapter S1110 page 2 | On page 2, updated the resource limits for the QMB, SLMB and QI covered groups for 2011. |
| Subchapter S1130 pages 28, 33 | On pages 28 and 33, clarified that the burial fund exclusion is reduced by any irrevocable burial arrangement. |
| Subchapter M1310 page 4 | On page 4, clarified the definition of an old bill. |
| Subchapter M1320 page 1 | On page 1, clarified the definition of an old bill. |
| Subchapter S1340 page 6 | On page 6, clarified the definition of an old bill. |
| Subchapter M1410 Page 13 | On page 13, clarified to which long-term care provider the DMAS-225 form is sent when there are multiple providers |
| Subchapter M1450 pages 4, 24,32, 36, 37 pages 39, 42, 43 | On page 4, clarified that the asset transfer policy applies to individuals receiving PACE and hospice services. On page 24, clarified the policy on service contracts. On page 32, updated the average monthly private nursing facility cost for 2011. On pages 36 and 37, revised the policy on when an asset transfer penalty period begins. On page 39, clarified that the undue hardship claims cannot be used to dispute the value of a resource. On pages 42 and 43, clarified the language that must be included on the Notice of Action or Advance Notice of Proposed Action when a penalty period is imposed. |

| Pages Changed | Significant Changes |
|---|--|
| Subchapter M1460 pages 3, 4, 35 | On pages 3 and 4, updated the home equity limit for 2011. On page 35, updated the blind or disabled student child earned income exclusion amount for 2011. |
| Subchapter M1470 pages 9, 19, 20, 23 | On pages 9 and 23, updated the Medicare Part D benchmark premium amount for 2011. On page 19, updated the personal allowance amounts for 2011. On page 20, updated the special earnings allowance amounts for 2011. |
| Subchapter M1480 pages 7-9, 13, 18a, 18c pages 66, 69, 70 | On pages 7 and 8, updated the home equity limit for 2011. On pages 9 and 13, clarified that the burial fund exclusion is only given when the applicant has designated funds to be used for burial. On page 18a, clarified the information needed to make a claim of undue hardship. On page 18c, updated the spousal resource standards for 2011. On page 66, updated the maximum monthly maintenance needs allowance and utility standard amounts for 2011. On page 69, updated the personal maintenance allowance amounts for 2011. On page 70, updated the special earnings allowance amounts for 2011. |
| Subchapter M1510 pages 8, 11, 12 | On page 8, clarified when an application is reopened subsequent to a determination of disability on appeal. On pages 11 and 12, added policy requiring the eligibility worker to try to obtain verification of a TPL cancellation prior to cancelling the TPL in MMIS and make a referral to DMAS if the verification cannot be obtained. |
| Subchapter M1520 pages 7, 21 | On page 7, added policy on renewals for the QI covered group and removed reference to an obsolete form. On page 21, revised the policy on handling cases transferred from the DMAS FAMIS Plus Unit. |
| Chapter M18 page 9 | On page 9, clarified that providers can charge dually eligible and QMB individuals the Medicare copayment amounts but must reimburse the difference between the Medicare and Medicaid copayments once Medicaid pays the claim. |
| Chapter M21 pages 5, 6, 14 Appendix 1 | On pages 5 and 6, clarified that Medicare is considered to be creditable health insurance. On page 14, added policy on FAMIS administrative renewals, conducted by the FAMIS Central Processing Unit. In Appendix 1, updated the FAMIS income limits for 2011. |
| Chapter M22 pages 4-6 Appendix 1 | On pages 4-6, clarified that Medicare is considered to be creditable health insurance. In Appendix 1, updated the FAMIS MOMS income limits for 2011. |

Please retain this transmittal letter for future reference. 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.

A handwritten signature in black ink, appearing to read "Martin D. Brown", written over a horizontal line.

Martin D. Brown
Commissioner

Electronic Attachment

Virginia DSS, Volume XIII

M0110 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|----------------------|
| TN #95 | 03/01/11 | Pages 2-4a |
| TN #94 | 09/01/10 | pages 2, 3 |
| TN #93 | 01/01/10 | pages 1, 6 |

- 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. Use of System Searches

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

c. Release of Information to Medical Providers

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

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to

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

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

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

d. Release to Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative. It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

e. Safeguarding Client Information

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

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;

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

f. Ownership of Records

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

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

g. Release of Client Information with Consent

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

h. Release of Client Information without Consent

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

Client information may be disclosed without client consent in these situations:

- to employees of state and local departments of social services for the purpose of program administration;
- to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;
- between state/local department of social services staff and DMAS for the purpose of supervision and reporting;
- to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and
- for the purpose of recovery of monies for which third parties are liable for payment of claims.

***i.* Client's Right of Access to Information**

(1) Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

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

M0120 Changes

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

M0120.000 Medical Assistance Application

M0120.100 Right to Apply

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

M0120.200 Who Can Sign the Application

- A. Patients in DBHDS Facilities** Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications submitted and signed by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.
- B. Applicants Age 18 or Older** The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the "committee" for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative.

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

If the applicant cannot sign his or her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

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

Witness's signature: _____

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

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

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

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

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

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

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

E. Unsigned Application

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

F. Invalid Signature

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

G. Enrollee Turns 18

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

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

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

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

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

1. Exception for Certain Newborns

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

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

**2. Forms That
Protect the
Application Date**

a. ADAPT Request for Assistance

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

b. Model Application for Medicare Premium Assistance Form

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

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

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

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

d. Eligibility Determination and Enrollment

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

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

E. Individuals In Virginia Veteran's Care Center

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

F. Incarcerated Individuals Pre-release Planning

Inmates of state correctional facilities may apply for Medicaid as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the inmate was living prior to incarceration. Applications are to be processed in the same manner and within the same processing time standards as any other Medicaid application, but if the incarcerated individual is found eligible, he is **not** enrolled in the Medicaid program until after he has been released from the correctional facility.

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

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

a. Department of Corrections Procedures

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

- The correctional facility staff will complete the Medicaid application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.
- The correctional facility staff will request a pre-admission screening for nursing home or community-based care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.

M0130 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|----------------------|
| TN #95 | 03/01/11 | page 8 |
| TN #94 | 09/01/10 | pages 2-6, 8 |
| TN #93 | 01/01/10 | pages 4-6, 8 |
| Update (UP) #2 | 08/24/09 | pages 8, 9 |

TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

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

G. Health Insurance Premium Payment (HIPP) Program

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

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

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

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

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

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

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

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

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

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

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

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| TN #95 | 3/1/11 | Table of Contents pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 pages 20a, 23, 24 Appendices 1-2a were removed. Appendix 3 and Appendices 5-8 were reordered and renumbered. |
| TN #94 | 9/1/10 | pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3 |
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1. **Exceptions to Verification Requirements**
- The following groups of individuals are NOT required to provide verification of C&I. Document in the case record why an individual is exempt from verifying C&I:
- a. All foster care children and IV-E Adoption Assistance children;
 - b. Individuals born to mothers who were eligible for Medicaid in any state on the date of the individuals' birth;
 - c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

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

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

2. **Verification Required One Time**
- Once verification of C&I has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. C&I documentation must be stored in the case record.
3. **Enroll Under Good Faith Effort**
- If an individual meets all other Medicaid eligibility requirements and declares that he is a citizen, he is to be enrolled under a good faith effort. **Do not request verification of C&I from the applicant, and do not delay or deny application processing for proof of C&I.**

If the applicant meets all other Medicaid eligibility requirements:

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

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

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

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

1. MMIS Data Matches SSA

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

2. MMIS Data Does Not Match SSA

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

a. SSA Cannot Verify C&I

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

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

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

b. Individual Does Not Provide Verification in 90 Days

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

M0220.200 ALIEN IMMIGRATION STATUS

- A. Introduction** An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.
- B. Procedure** An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.
- If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.700 to enroll an eligible emergency services alien in Medicaid for emergency services only.
- C. Changes in Immigration Status** *If a "full benefit" alien who was admitted to the U.S with immigration status in one of the "seven-year" alien groups listed in M0220.313.A becomes a Lawful Permanent Resident, he is considered to have full benefit status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S.*

M0220.201 IMMIGRATION STATUS VERIFICATION

- A. Verification Procedures** An alien's immigration status is verified by the official document issued by the *United States Citizenship and Immigration Services* (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. The EW must see the original document or a photocopy. Submission of just an alien number is NOT sufficient verification.
- If the alien has an alien number but no USCIS document, or has no alien number and no USCIS document, use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.
- NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.
- B. Documents That Verify Status** Verify lawful permanent resident status by a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on Form I-94.
- Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).
- Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

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

C. Letters that Verify Status

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

D. Local USCIS Office Documents

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

E. Expired or Absent Documentation

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

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

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

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

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

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

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

1. Primary Verification

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

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

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

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

2. Secondary Verification

Secondary verification is required in the following situations:

- a. The alien has an alien number but no USCIS document, or the alien has no alien number and no USCIS document.
- b. Primary verification generates the message "Institute Secondary Verification" or "No File Found."
- c. Discrepancies are revealed when comparing primary verification to the original immigration document.
- d. Immigration documents have no Alien Registration Number (A-Number).
- e. Documents contain an A-Number in the A60 000 000 or A80 000 000 series.
- f. The document presented is an USCIS Fee Receipt.
- g. The document presented is Form I-181 or I-94 in a foreign passport that is endorsed "Processed for I-551, Temporary Evidence of Lawful Permanent Residence," and the I-181 or I-94 is more than one year old.

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

B. Document Verification Request (Form G-845)

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

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

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

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

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

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

Acceptable documentation includes:

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

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

C. Agency Action

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

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

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

- B. Services Available To Eligibles** A qualified alien who entered the U.S. before 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.
- C. Entitlement & Enrollment of Eligibles** The Medicaid entitlement policy and enrollment procedures for eligible qualified aliens who entered the U.S. before 8-22-96 are found in section M0220.600 below.

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

- A. First 7 Years of Residence in U.S.** During the first seven years of residence in the U.S., six (6) groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements), *even if their status is adjusted later to LPR.* These 6 groups of qualified aliens who entered the U.S. on or after 8-22-96 are:
- 1. Refugees** Refugees under section 207 and Amerasian immigrants are full benefit aliens for 7 years from the date of entry into the U.S. Once 7 years have passed from the date the refugee entered the U.S., the refugee becomes an "emergency services" alien.
 - 2. Asylees** Asylees under section 208 are full benefit aliens for 7 years from the date asylum in the U.S. is granted. Once 7 years have passed from the date the alien is granted asylum in the U.S., the asylee becomes an "emergency services" alien.
 - 3. Deportees** Deportees whose deportation is withheld under section 243(h) or section 241(b)(3) are full benefit aliens for 7 years from the date withholding is granted. After 7 years have passed from the date the withholding was granted, the deportee becomes an "emergency services" alien.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.313 above, the alien is a full benefit alien.
 - 4. Cuban or Haitian Entrants** Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 are full benefit aliens for 7 years from the date they enter the U.S. After 7 years have passed from the date they entered the U.S., a Cuban or Haitian entrant becomes an "emergency services" alien.
 - 5. Victims of a Severe Form of Trafficking** Victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000, P.L. 106-386 are full benefit aliens for 7 years **from the date they are certified or determined eligible** by the Office of Refugee Resettlement (ORR). Victims of a severe form of trafficking are identified by either a letter of certification (for adults) or a letter of eligibility (for children)

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

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

The Department of Defense Appropriations Act of 2010, enacted on December 19, 2009, provides that Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits to the same extent and for the same time period as refugees. The legislation supersedes prior legislative authority that limited Special Immigrants to benefits for an 8-month time period. Provided that all other eligibility requirements are met, Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits for the first seven years after entry into the United States (U.S.).
- 7. After 7 Years Residence in U.S.**

After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
- B. AFTER 5 Years of Residence in U.S.**

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

 - 1. LPR**

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

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

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

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

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

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

C. Services Available To Eligibles

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

The following immigrants:

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

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

2. LPR With 40 Work Quarters

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

D. Entitlement & Enrollment of Eligibles

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

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

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

M0220.400 EMERGENCY SERVICES ALIENS

- A. Policy** Any alien who does NOT meet the requirements for full benefits as described in section M0220.300 through 314 above is an “emergency services” alien and is eligible for emergency Medicaid services only, if he or she meets all of the Medicaid nonfinancial and financial eligibility requirements.
- B. Procedure** Section M0220.410 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.
- Section M0220.411 defines “unqualified” aliens.
- Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.
- Section M0220.700 contains the entitlement and enrollment procedures for emergency services aliens.

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

- A. First 5 Years of Residence in U.S.** During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for **emergency Medicaid services only** provided they meet all other Medicaid eligibility requirements.
- 1. LPRs** An LPR who enters the U.S. on or after 8-22-96 is an “emergency services” alien during the first 5 years the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior *immigration status in one of the “seven-year” alien groups listed in M0220.313.A*, he is considered to have “seven year” status for the purposes of Medicaid eligibility *for the first seven years of residency in the U.S.* To determine former status of a LPR, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. *Contact the USCIS at 1-800-375-5283 for assistance in identifying the former status for other seven year aliens.*
 - 2. Conditional Entrants** A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 - 3. Parolees** A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 - 4. Battered Aliens** A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- B. AFTER 5 Years of Residence in U.S.** **AFTER** 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:

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

- E. Services Available To Eligibles** An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.
- F. Entitlement & Enrollment of Eligibles** The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below.

M0220.411 UNQUALIFIED ALIENS

- A. Unqualified Aliens** Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** legal immigrant children under age 19 (M0220.314 above) are “unqualified” aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.
- B. Illegal aliens** Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.
- C. Non-immigrant Aliens** Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). Non-immigrants have the following types of USCIS documentation:
- Form I-94 Arrival-Departure Record,
 - Form I-185 Canadian Border Crossing Card,
 - Form I-186 Mexican Border Crossing Card,
 - Form SW-434 Mexican Border Visitor's Permit,
 - Form I-95A Crewman's Landing Permit.

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

Non-immigrants include:

1. **Visitors** visitors for business or pleasure, including exchange visitors;
2. **Foreign Government Representative** foreign government representatives on official business and their families and servants;
3. **Travel Status** aliens in travel status while traveling directly through the U.S.;
4. **Crewmen** Crewmen on shore leave;
5. **Treaty Traders** treaty traders and investors and their families;

- | | |
|--------------------------------------|--|
| 6. Foreign Students | foreign students; |
| 7. International Organization | international organization representatives and personnel, and their families and servants; |
| 8. Temporary Workers | temporary workers including some agricultural contract workers; |
| 9. Foreign Press | members of foreign press, radio, film, or other information media and their families. |

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

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

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

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

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

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

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

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

- A. Policy** An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.
- B. Application & Entitlement**
- 1. Application Processing** The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.
 - 2. Entitlement** If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.
 - 3. Spenddown** Spenddown provisions apply to medically needy individuals who have excess income.
 - 4. Notice** Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.
- C. Enrollment Procedures** Once a full benefit alien is found eligible for Medicaid, he must be enrolled on the Medicaid computer (MMIS) using the following data:
- 1. Country** In this field, Country, enter the code of the alien's country of origin.
 - 2. Cit Status** In this field, Citizenship Status, enter the MMIS Citizenship code that applies to the alien. Below, next to the MMIS code, is the corresponding Alien Code from the Alien Code Chart in Appendix 5 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)
 - 3. Entry Date** **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
 - 4. Appl Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
 - 5. Coverage Begin Date** In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.

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

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

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

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

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

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

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

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

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

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

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

D = Emergency services alien who receives dialysis.

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

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

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

3. **Entry date** **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
4. **App Dt** In this field, application date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
5. **Covered Dates Begin** In this field, coverage begin date, enter the begin date of the emergency service(s).
6. **Covered Dates End** In this field, coverage end date, enter the date when the alien's emergency service(s) ends. When the emergency service(s) received was related to labor and delivery, the end date includes the day of discharge even though it is not counted to determine the length of stay for certification purposes.
7. **AC** Enter the code applicable to the alien's covered group.
- D. Notices** Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility.
- The USCIS requires that all benefit applicants who are denied benefits based solely or in part on the SAVE response be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The fact sheet, "Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS" (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, **including the approval of emergency-services-only Medicaid coverage**, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. The fact sheet is available on PARK at <http://www.localagency.dss.state.va.us/divisions/dgs/warehouse.cgi>.*
- A Medicaid card will not be generated for an individual enrolled as an emergency services alien.
- The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628, Emergency Medical Certification, to the provider(s).

Citizenship & Identity Procedures and Documentation Charts

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

A. Documents

Establishing U.S. Citizenship and Identity

1. Citizenship Document

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

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

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

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

2. Identity Document

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

3. Acceptable Documents

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

Exceptions:

- a. A copy of a **Virginia birth certificate** that is in the existing LDSS agency record, or is presented by an individual as verification, is acceptable temporarily while the LDSS agency is waiting for verification of the Virginia birth record from the Birth Record Verification System (BRVS). The agency may approve or renew coverage if the individual meets **all** other eligibility requirements. The agency must obtain verification of the Virginia birth record from BRVS, and a copy of the BRVS Birth Record Verification Results screen for the individual must be placed in the record when received. BRVS is accessed on SPARK. The procedures for using BRVS are in the BRVS User Guide, available in BRVS.*
- b. Puerto Rico invalidated all birth certificates issued prior to July 1, 2010 and reissued the birth certificates. For individuals born in Puerto Rico **who are applying for Medicaid for the first time**, only a birth certificate issued on or after July 1, 2010 may be accepted from the individual. Should an individual born in Puerto Rico be unable to present a birth certificate issued on or after July 1, 2010, contact your Regional Medical Assistance Specialist, who will refer the case to DMAS. DMAS will obtain official birth verification on behalf of the local DSS. If the person is reapplying and the agency has a birth certificate issued prior to July 1, 2010 on record, no additional verification is required.*

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

4. Levels of Acceptable Documents

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

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

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

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

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

5. How to Verify Citizenship and Identity

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

6. How to Verify Citizenship

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

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

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

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

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

7. How to Verify Identity

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

a. Children Under Age 16

A written affidavit for a child under age 16 may be used to verify the child's identity **if an affidavit was not used to prove the child's citizenship** and the identity affidavit language is not on the application, ADAPT Statement of Facts (SOF) or renewal form submitted by the individual. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is on the intranet at:
<http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf>.

The Health Insurance for Children and Pregnant Women application form, form number 032-03-0401, has been updated to include the identity affidavit language. The application form is available on the intranet at:
<http://localagency.dss.virginia.gov/divisions/bp/me/forms/famis.cgi>. The Families & Children Medicaid and FAMIS Plus Renewal form contains the identity affidavit language. The form is available on the intranet at:
<http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

b. Individuals Age 16 or Older

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

B. Hierarchy of Documentation

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

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

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

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

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

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

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

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

| LEVEL 1 – Primary Documents | Explanation – Level 1 |
|--|---|
| * United States Passport | <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>Exceptions: (1) Do not accept any passport as evidence of United States citizenship when it was issued with a limitation; (2) do not accept an expired passport issued to a person born in Puerto Rico as evidence of citizenship. However, such passports may be used as proof of identity only.</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> |
| * Certificate of Citizenship (N-560 or N-561) | <p>Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.</p> |

**2. LEVEL 2 -
Secondary
Documents to
Establish
United States
Citizenship**

Level 2 secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. Available evidence is evidence that exists and can be obtained within the application processing time frame (see section M0130.100). **A second document establishing identity MUST also be presented (see Chart 5, Evidence of Identity).**

Accept any of the documents listed in the Level 2 table as secondary evidence of United States citizenship if the document meets the listed criteria and there is nothing indicating the person is not a United States citizen (e.g., lost United States citizenship).

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

| LEVEL 2 – Secondary Documents | Explanation – Level 2 |
|--|--|
| <p>A United States public birth record</p> | <p>A United States public birth record showing birth in:</p> <ul style="list-style-type: none"> • one of the 50 United States; • District of Columbia; • Puerto Rico (if born on or after January 13, 1941 <i>AND document was issued on or after July 1, 2010 or official verification is obtained by DMAS</i>); • Guam (on or after April 10, 1899). • Virgin Islands of the United States (on or after January 17, 1917); • American Samoa; • Swain's Island; or • Northern Mariana Islands (after November 4, 1986 (NMI local time)). <p>The birth record document may be recorded by the State, Commonwealth, Territory or local jurisdiction. It must have been recorded before the person was 5 years of age. A delayed birth record document that is recorded after 5 years of age is considered fourth level evidence of citizenship.</p> <p>Plastic birth certificate cards issued by the Virginia Department of Health are valid birth certificates. A copy of the card is to be placed in the case record, with a note that the original card was viewed. Other states may have issued similar plastic birth certificate cards. If an individual presents a plastic birth certificate card from another state, verify with that state’s office of vital records that such cards are issued by the state.</p> |
| | <p>NOTE: Individuals born to foreign diplomats residing in one of the states, the District of Columbia, Puerto Rico, Guam or the Virgin Islands are not citizens of the United States.</p> |
| <p>Collective Naturalization</p> | <p>If the document shows the individual was born in Puerto Rico, the Virgin Islands of the United States, or the Northern Mariana Islands before these areas became part of the United States, the individual may be a collectively naturalized citizen. Collective naturalization</p> |

| LEVEL 2 – Secondary Documents | Explanation – Level 2 |
|-------------------------------|---|
| | |
| Collective Naturalization | occurred on the dates listed for each of the Territories. The following will establish United States citizenship for collectively naturalized citizens: |
| | <ul style="list-style-type: none"> • a. Puerto Rico: <ol style="list-style-type: none"> 1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the United States, a United States possession or Puerto Rico on January 13, 1941; or 2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain. b. United States Virgin Islands: <ol style="list-style-type: none"> 1) Evidence of birth in the United States Virgin Islands, and the applicant's statement of residence in the United States, a United States possession or the United States Virgin Islands on February 25, 1927; or |
| | <ol style="list-style-type: none"> 2) The applicant's statement indicating residence in the United States Virgin Islands as a Danish citizen on January 17, 1917 and residence in the United States, a United States possession or the United States Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or 3) Evidence of birth in the United States Virgin Islands and the applicant's statement indicating residence in the United States, a United States possession or Territory or the Canal Zone on June 28, 1932. <ul style="list-style-type: none"> c. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)): <ol style="list-style-type: none"> 1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the United States, or a United States Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or 2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or |

| LEVEL 2 – Secondary Documents | Explanation – Level 2 |
|--|--|
| Collective Naturalization | <p>3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).</p> <p>4) NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a United States citizen.</p> |
| *Certification of Report of Birth (DS-1350) | <p>The Department of State issues a DS-1350 to United States citizens in the United States who were born outside the United States and acquired United States citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the United States.</p> |
| *Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240) | <p>The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.</p> |
| *Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350) | <p>Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.</p> |
| U.S. Citizen Identification Card | <p>(This form was issued as Form I-197 until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act. Note that section 1903(x) of the Act incorrectly refers to the same document as an I-97). INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.</p> |
| Northern Mariana Card (I-873) | <p>Issued by the DHS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986). The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.</p> |
| American Indian Card (I-872) | <p>(Issued by DNS to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border). DHS issues this card to identify a member of the Texas Band of Kickapoos living near the</p> |

| LEVEL 2 – Secondary Documents | Explanation – Level 2 |
|--|--|
| | U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship. |
| Final adoption decree showing the child’s name and a U.S. place of birth | The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate. |
| Evidence of civil service employment by the U.S. government | The document must show employment by the U.S. government before June 1, 1976. |
| Official Military record of service | The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth). |
| Child Citizenship Act of 2000 | <p>Adopted or biological children born outside the U.S. may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 U.S.C. § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted October 30, 2000). The agency must obtain documentary evidence that verifies that at any time on or after February 27, 2001, the following conditions have been met:</p> <ul style="list-style-type: none"> • At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the Medicaid eligibility requirements); • The child is under the age of 18; • The child is residing in the United States in the legal and physical custody of the U.S. citizen parent; • The child was admitted to the United States for lawful permanent residence (as verified under the requirements of 8 U.S.C. 1641 pertaining to verification of qualified alien status); and • If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 U.S.C. § 1101(b)(1) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred). |

3. LEVEL 3 – Third Level Documents to Establish U.S. Citizenship

Level 3 third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used **ONLY** when the following conditions exist:

- primary evidence cannot be obtained within the State's reasonable opportunity period (see reasonable opportunity discussion below),

- secondary evidence does not exist or cannot be obtained, **and**
- the applicant or recipient alleges being born in the U.S.

In addition, a second document establishing identity MUST be presented as described in Chart 5, “Evidence of Identity.”

Third level evidence is generally a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree. Accept any of the documents listed in the Level 3 table as third level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges birth in the U.S., and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

| LEVEL 3 - Third Level Documents | Explanation – Level 3 |
|---|--|
| Extract of hospital record on hospital letterhead established at the time of the person’s birth that was created 5 years before application and indicates a U.S. place of birth | <p>An extract of a hospital record on hospital letterhead that was established at the time of the person's birth, that was created at least 5 years before the initial Medicaid application date and that indicates a U.S. place of birth is acceptable.</p> <p>Do not accept a birth certificate “souvenir” issued by the hospital.</p> <p>NOTE: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.</p> |
| Life, health or other insurance record created at least 5 years before initial Medicaid application date and indicates a U.S. place of birth | <p>Life, health or other insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth and it was created at least 5 years before the initial Medicaid application date.</p> <p>NOTE: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.</p> |
| Religious record recorded in the U.S. showing a U.S. place of birth | <p>Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual’s age at the time the record was made. The record must be an official record recorded with the religious organization.</p> |
| | <p>CAUTION: In questionable cases (for example, where the child’s religious record was recorded near a U.S. international border and the child may have been born outside the U.S.), the agency must verify the religious record and/or document that the individual’s mother was in the U.S. at the time of the individual’s birth.</p> |
| Early school record showing a U.S. place of birth | <p>The early school record showing a U.S. place of birth must be from a Head Start program, a pre-school, kindergarten or elementary school (early school records do NOT include report cards). The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant’s parents.</p> |

**4. LEVEL 4 -
Fourth Level
Documents**

Level 4 fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should ONLY be used in the rarest of circumstances. This level of evidence is used ONLY when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity MUST be presented as described in Chart 5, Evidence of Identity. Available evidence is evidence that can be obtained within the State's reasonable opportunity period as discussed below.

Fourth level evidence, as described in the Level 4 table below, consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and the application must agree. Accept any of the documents listed in the Level 4 table as fourth level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges U.S. citizenship, and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship). A second document establishing identity must be presented.

The written affidavit described in the Level 4 table may be used only when the State is unable to secure evidence of citizenship listed in any other Level.

| LEVEL 4 - Fourth Level Documents | Explanation – Level 4 |
|--|--|
| Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950). | The census record must also show the applicant's age. NOTE: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or agency should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Add that the purpose is for Medicaid eligibility. This form requires a fee. |
| One of the documents listed that was created at least 5 years before the application for Medicaid | The other document must be one of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for Medicaid. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) This document must be one of the following and must show a U.S. place of birth: <ul style="list-style-type: none"> • Seneca Indian tribal census record, • Bureau of Indian Affairs tribal census records of the Navaho Indians, • U.S. State Vital Statistics official notification of birth registration, • A delayed U.S. public birth record that is recorded more than 5 years after the person's birth, |

| LEVEL 4 - Fourth Level Documents | Explanation – Level 4 |
|---|---|
| | <ul style="list-style-type: none"> • Statement signed by the physician or midwife who was in attendance at the time of birth, or • The Roll of Alaska Natives maintained by the Bureau of Indian Affairs. |
| <p>Institutional admission papers created at least 5 years before the initial application date</p> | <p>Institutional admission papers from a nursing facility, skilled nursing care facility, a local, state or federal prison or other institution created at least 5 years before the initial application date that indicate a U.S. place of birth are acceptable. Admission papers generally show biographical information for the person including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth.</p> |
| <p>Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date and indicates a U.S. place of birth.</p> | <p>Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth and was created at least 5 years before the initial application date.</p> <p>NOTE: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.</p> <p>NOTE: For children under 16 the document must have been created near the time of birth or 5 years before the date of Medicaid application.</p> |
| <p>Written affidavit of citizenship</p> | <p>Affidavits should ONLY be used in rare circumstances. When the LDSS is unable to secure any other form of documentation of citizenship listed above within the allowed processing time frame, a written affidavit described below may be accepted for citizens born in the U.S. and for naturalized citizens. The individual must also provide documentation of identity.</p> <p>NOTE: The Affidavit of Identity for Medicaid Applicants/Recipients Under Age 16 cannot be used when an affidavit of citizenship is used.</p> <p>If the citizenship documentation requirement needs to be met through affidavits, the following rules apply:</p> <ul style="list-style-type: none"> • There must be at least two affidavits by two individuals who are United States citizens, including naturalized citizens, who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • At least one of the individuals making the affidavit cannot be related to the applicant/recipient. Neither of the two individuals can be the applicant/recipient. • In order for the affidavits to be acceptable, the persons making the affidavits must be able to provide proof of their own citizenship and identity. • If the individuals making the affidavits have information which explains why documentary evidence establishing the |

| LEVEL 4 - Fourth Level Documents | Explanation – Level 4 |
|----------------------------------|---|
| Written affidavit of citizenship | <p>applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well.</p> <ul style="list-style-type: none"> • The agency must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (or guardian or representative) explaining why the evidence does not exist or cannot be readily obtained. • The affidavits must be signed under penalty of perjury by the persons making the affidavits. <p>The Affidavit of Citizenship On Behalf Of Medicaid Applicants and Recipients, to be used by the two persons attesting to the applicant/recipient’s citizenship, is available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0280-00-eng.doc.</p> <p>The Affidavit of Citizenship By Medicaid Applicants and Recipients, to be used by the applicant/recipient or his guardian or authorized representative, is available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0281-00-eng.doc</p> |

5. CHART 5 - Evidence of Identity

Section 1903 (x) of the Act provides that identity must be established. When Level 1 primary evidence of citizenship is not available, a document from the Level 2, Level 3 or Level 4 tables above may be presented if accompanied by an identity document from the following Chart 5 Identity Documents table. The identity documents do not have a hierarchy of reliability.

Exception to Identity Documentation: Do not accept a **voter’s registration card** or **Canadian driver’s license** [as listed in 8 CFR 274a.2 (b) (1) (v) (B) (1)].

| CHART 5 – Identity Documents | Explanation – Chart 5 |
|------------------------------|---|
| Driver’s license | A driver's license issued by State or Territory either with a photograph of the individual, or other identifying information such as name, age, sex, race, height, weight or eye color, is acceptable. |
| School identification card | A school identification card with the name and photograph of the individual is acceptable. The school ID card must be an official ID card issued by the school; unofficial ID cards such as those provided as a courtesy with school photographs, are not acceptable. |

| CHART 5 – Identity Documents | Explanation – Chart 5 |
|---|--|
| United States military card or draft record | United States military card or draft record is acceptable. |
| Identification card issued by the Federal, State, or local government | An identification card issued by the Federal, State, or local government with the same information included on driver's licenses is acceptable. At a minimum, the ID must have the individual's name, address and photo. For photo ID cards, the photo must have been affixed to the ID card by the government agency that issued it. ID cards issued by a government agency that just have a space for the individual to attach a photo are NOT acceptable. |
| Military dependent's ID card | A military dependent's identification card is acceptable. |
| Native American Tribal document | A Native American Tribal document is acceptable. |
| United States Coast Guard Merchant Mariner card | A United States Coast Guard Merchant Mariner card is acceptable. |
| Certificate of Degree of Indian Blood, or other United States American Indian/Alaska Native tribal document | A Certificate of Degree of Indian Blood, or other United States American Indian/Alaska Native tribal document with a photograph or other personal identifying information relating to the individual is acceptable. The other personal identifying information relating to the individual on the document must be information such as age, weight, height, race, sex, and eye color. |
| State Agency Computer Data | <p>Identifying information from a Virginia state governmental data system can be used to provide identity verification for applicants and recipients. A copy of the screen(s) from a state data system that shows the individual's name, DOB, gender and SSN is acceptable documentation of the individual's identity if the agency establishes the true identity of the individual.</p> <p>NOTE: The state computer data base can only be used for identity verification; it cannot be used for verifying citizenship.</p> |
| Three or more corroborating documents | <p>The agency may accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The agency must first ensure that no other evidence of identity is available to the individual prior to accepting such documents.</p> <p>The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All three documents used must contain consistent identifying information.</p> |

| CHART 5 – Identity Documents | Explanation – Chart 5 |
|--|--|
| Three or more corroborating documents | Examples of these documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles. |
| Death Certificate | An official death certificate can be used to verify the identity of a deceased Medicaid applicant. NOTE: a death certificate CANNOT be used to verify citizenship. |
| Special identity rules for children under age 16 | <p>For children under 16, when the application form does not contain the parent or caretaker’s statement of identity for children under age 16, a clinic, doctor, hospital or school record may be accepted for purposes of establishing identity. School records may include nursery or child care records and report cards that contain the required information.</p> <p>The school, nursery or daycare record must contain the child’s name, date of birth, place of birth and the parents’ names. The form agencies should use to request the school, nursery or daycare record is posted on the intranet. The school record request form workers can give to a child’s parent or caretaker to give to the school is posted to the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi.</p> |
| | <p>a. Foster Care and Title IV-E Adoption Assistance Children</p> <p>All foster care children and Title IV-E Adoption Assistance children are excluded from the citizenship and identity verification requirements. Non-Title-IV-E Special Medical Needs children and non-Title-IV-E adoption assistance children must verify their citizenship and identity.</p> <p>b. Written affidavit of identity</p> <p>For children under 16 only, an affidavit of identity may be used when the application or renewal form does not contain the identity affidavit language. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or caretaker stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided for the child. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is available on the LDSS Intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf and may be sent to the parent or caretaker with the application or renewal form that does not contain the identity affidavit language when the agency is aware that a child under age 16 is in the home.</p> <p>The Application for Health Insurance for Children and Pregnant Women (FAMIS 1) and the Families& Children Medicaid and FAMIS Plus Renewal form contain an area for the parent or caretaker to attest</p> |

| CHART 5 – Identity Documents | Explanation – Chart 5 |
|--|--|
| Special identity rules for children under age 16 | <p>to the identity of a child under age 16. The forms are available on the intranet. A separate affidavit of identity is not necessary when the parent or caretaker has attested to identity on the application or renewal form.</p> <p>The affidavit of identity, or the attestation of identity on the original application form, remains valid when the child reaches age 16 or older, as long as the child remains continuously enrolled in Medicaid. If the child’s enrollment is canceled and he reapplies after turning age 16, his identity must be verified.</p> |
| Special rules for individuals in institutions | <p>The agency may accept an identity affidavit signed under penalty of perjury by a director or administrator of a residential care facility (such as an assisted living facility or group home), nursing home or hospital on behalf of an institutionalized individual who is residing or is an inpatient in the facility. The affidavit is not required to be notarized. The agency should first pursue other means of verifying identity prior to accepting an affidavit.</p> <p>The Affidavit of Identity for Medicaid Applicants/Recipients Residing in an Institution form is available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi.</p> |

C. Agency Actions

1. Documentation From Case Record and Individual

Documentation of citizenship and/or identity may be obtained from a number of different sources including the following:

- Existing LDSS agency records as long as the documentation conforms to Medicaid policy for citizenship and identity verification in M0220 of the Medicaid Eligibility Manual.
- Applicants and Recipients. All applicants and recipients, **except** SSI recipients, Medicare beneficiaries, SSDI beneficiaries, individuals born to Medicaid-eligible mothers, all foster care children and IV-E Adoption Assistance children, must provide documents that show proof of United States citizenship and proof of the person’s identity. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.
- *DMAS, for individuals born in Puerto Rico who are unable to provide a birth certificate issued on or after July 1, 2010. Contact the Regional Medical Assistance Program Specialist for assistance.*

Original documents may be viewed by all eligibility, administrative, and services staff of the LDSS as long as the person viewing the document makes a copy of the document, notes that the original was viewed, and signs and dates the copy.

2. Authorized Representative

For individuals who have authorized representatives, such as the disabled or individuals who are institutionalized, initiate efforts to assist in securing documentation with the appropriate representative.

In those instances in which an authorized representative lives in another locality than the Medicaid enrollee and the authorized representative's LDSS is more convenient to them than the locality where the case is maintained, a LDSS may copy and verify an original document for an authorized representative. The LDSS is not to give the copy to the client's representative; the agency staff must send it to the LDSS that holds the Medicaid enrollee's case. In this way, the "chain of evidence" is not broken—it has always stayed within DSS.

A local DSS agency may accept the copy as verification providing another LDSS:

- saw the original document,
- made the copy of the original,
- wrote on the copy that the staff member saw the original document on (date), and
- signed and dated the copy.

3. Documents From Other Approved Organizations

Original citizenship and identity documents can be accepted from other organizations approved by DMAS when the original document is viewed, the authorized person makes a copy and affixes a statement to the copy that has the following information:

- the original document was viewed and copied by (name and title of the individual who viewed the documentation), signature of staff member who saw the original,
- the name of the entity with which the individual is affiliated, and
- the date the documentation was viewed and copied.

DMAS has approved documentation copies from the following:

- an established outreach organization,
- local health department,
- Department of Corrections personnel for prisoners leaving the correctional system,
- Federally Qualified Health Centers (FQHC),
- hospital discharge planners or social workers.

Two lists of approved organizations are posted on the local agency intranet site: "Project Connect and Independent Outreach Projects List" and "FQHC-Virginia Primary Care Association Membership Roster".

Hospital contractors, such as Chamberlin-Edmonds, are **not** considered authorized to view original documents.

4. DMAS FAMIS Plus Unit

Original documents can be viewed by local department of social services (LDSS) for applications handled by the Department of Medical Assistance Services (DMAS) FAMIS Plus Unit. As a service to clients, staff from any LDSS is to view an original document, make a copy, and note on the copy that the original was viewed, including the date and signature of the staff person. The LDSS are to send or fax the annotated copy to the DMAS FAMIS Plus

Unit. The DMAS FAMIS Plus Unit will accept the copy and place it in the record. This process will significantly reduce the likelihood of important and possibly irreplaceable documents being misplaced or destroyed.

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

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

6. Individuals Who No Longer Meet Exception

When an individual loses the exception status, and his citizenship and identity has not been previously verified, it must be verified for him to remain eligible for Medicaid. If the individual's eligibility in another covered group must be determined (due to the loss of SSI benefits, for example), obtain the documentation of citizenship and identity at the time of the eligibility review. If the verification is not readily available, the individual must be allowed a reasonable opportunity to obtain the documentation. See M0220.100 A 3.

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

7. Individual NOT Required to Submit Documents in Person

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

For individuals who need assistance securing a birth certificate, LDSS may request Virginia birth record verification via BRVS without receiving additional approval from the recipient beyond the recipient's original signature on the application for Medicaid. If the result of a BRVS request is "unverified," however, the individual is to be notified that documentation of citizenship is needed and allowed the reasonable opportunity period to secure the documentation (see M0220.100 A 3).

8. Special Populations Needing Assistance

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

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

- 9. Failure to Provide Requested Verifications** Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable opportunity to present such documentation, is to result in the termination of Medicaid.
- A recipient who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by a recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period.
- 10. Notification Requirements** Prior to the termination of benefits, the enrollee must be sent the Advance Notice of Proposed Action (Form 032-03-018) at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.
- A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.
- 11. Maintain Documents in Case Record** The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.
- 12. No Reporting Requirements** There are no monthly reporting requirements. However, the Medical Assistance Program Consultants may conduct reviews of cases where Medicaid eligibility was denied or terminated because of lack of citizenship and/or identity verification.
- 13. Refer Cases of Suspected Fraud to DMAS** If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

**Sample Letters of Certification/Eligibility for Victims of a
Severe Form of Trafficking**

[Used For Adults]

HHS Tracking Number

(Address)

CERTIFICATION LETTER

Dear _____:

This letter confirms that you have been certified by the U.S. Department of Health and Human Services (HHS) pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000. Your certification date is _____. Certification does not confer immigration status.

With this certification, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

**Sample Letters of Certification/Eligibility for Victims of a
Severe Form of Trafficking**

[Used For Children Under Age 18 Years]

HHS Tracking Number

(Address)

Dear _____:

This letter confirms that pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

Your initial eligibility date is _____. This letter does not confer immigration status.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents

This appendix contains the process for determining the number of qualifying quarters (QQ) with which a lawful permanent resident (LPR) who entered the U.S. on or after 8-22-96 can be credited and is to be used in conjunction with the State Verification Exchange System (SVES) User Guide.

I. Procedures:

A. To determine the number of QQ available to a LPR applicant, ask the applicant the following questions:

1. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) lived in this country?
2. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) commuted to work in the U.S. from another country before coming to the U.S. to live, or worked abroad for a U.S. company, or worked in self-employment while a legal resident of the U.S.?

(If the total number of years to both questions is less than 10 years, **STOP** because the applicant cannot meet the 40 QQ requirement.)

3. In how many of the years reported in the answer to question 1 did the applicant, the applicant's spouse, or the applicant's parent earn money through work?
- B. To determine whether the applicant's earnings were sufficient to establish "quarters of coverage" in those years, refer to the income chart in section II .

If the answer to question 3 is 10 years or more, verify from INS documents or other documents the date of entry into the country for the applicant, spouse and/or parent. If the dates are consistent with having 10 or more years of work, initiate a SVES inquiry.

- C. Complete or obtain from the applicant a completed "Consent for Release of Information" (see page 4 of this appendix) with the full name, social security number and date of birth of each individual (self, spouse, or parent) whose work history is relevant. In addition, the applicant must provide a form signed by each such individual, except deceased persons, giving SSA permission to release information through SVES on that individual to the agency and/or the applicant. Retain the consent form in the case file to document the individual's consent. A consent form is valid for 12 months from the time of the signature.

- D. Information received through SVES will not report earnings for the current year nor possibly the last year's earnings (i.e. the lag period). The SVES report will also not include employment that is not covered under Social Security (i.e. not requiring payment of FICA/Social Security tax). The applicant must provide verification of earnings through pay stubs, W-2 forms, tax records, employer records, or other documents, if quarters of the lag period or non-covered employment are needed to meet the 40-quarter minimum. Use the information contained in section II to determine QQ for lag periods and non-covered earnings.

If the alien believes the information from SSA is inaccurate or incomplete, beyond the current two-year lag period, advise the applicant to provide the verification to SSA to correct the inaccurate income records.

In evaluating the verification received directly from the applicant or through SVES, **exclude** any quarter, beginning January 1997, in which the person who earned the quarter received benefits from the TANF, SSI, or Medicaid, or SNAP Programs or the food assistance block grant program in Puerto Rico.

- E. In situations when consent to release information through SVES cannot be obtained from a parent or spouse, other than death, request information about quarters of coverage directly from the Social Security Administration. Complete or obtain from the applicant a Request for Quarters of Coverage (QC) History Based on Relation form, SSA-513. The form specify the period(s) for which the verification is requested. Submit the completed form to:

Social Security Administration
P.O. Box 33015
Baltimore, Maryland 21290-3015

- F. When the SSA is unable to determine if a quarter should be allowed, the SVES inquiry will show "Z" or "#" codes. If an applicant cannot meet the 40-quarter minimum without using a questionable quarter, SSA will investigate the questionable quarter(s) and will either confirm or deny the quarter. Use Form SSA-512, "Request to Resolve Questionable Quarters of Coverage (QC)," to resolve quarters before 1978. A copy of the SVES report must accompany the completed form. Submit Form SSA-512 to:

Social Security Administration
Office of Central Records Operations
P.O. Box 33015
Baltimore, Maryland 21290-3015

For questionable quarters for 1978 or later, the applicant must complete Form SSA-7008. "Request for Correction of Earnings." This form is available at local SSA offices. At the top of the form write "Welfare Reform." Submit the form and proof of earnings to:

Social Security Administration
Office of Central Records Operations
P.O. Box 30016
Baltimore, Maryland 21290-3016

II. Establishing Quarters:

Use the following information to (1) determine whether the applicant’s earnings as reported in section I.A were sufficient to establish quarters of coverage and (2) to determine the number of QQ during lag periods and when the reported employment is not a covered earning for Social Security reporting purposes:

- A quarter is a period of 3 calendar months ending with March 31, June 30, September 30 and December 31 of any year.
- Social Security quarters of coverage are credits earned by working at a job or as a self-employed individual. A maximum of four credits or quarters can be earned each year.
- For 1978 and later, credits are based solely on the total yearly amount of earnings. The number of creditable QQ are obtained by dividing the total earned income by the increment amount for the year. All types of earnings follow this rule. The amount of earnings needed to earn a credit increases and is different for each year. The amount of earnings needed for each credit and the amount needed for a year in order to receive four credits are listed below.

| <u>Year</u> | <u>Quarter Minimum</u> | <u>Annual Minimum</u> | <u>Year</u> | <u>Quarter Minimum</u> | <u>Annual Minimum</u> |
|-------------|------------------------|-----------------------|-------------|------------------------|-----------------------|
| 1978 | \$250 | \$1000 | 1991 | \$540 | \$2160 |
| 1979 | \$260 | \$1040 | 1992 | \$570 | \$2280 |
| 1980 | \$290 | \$1160 | 1993 | \$590 | \$2360 |
| 1981 | \$310 | \$1240 | 1994 | \$620 | \$2480 |
| 1982 | \$340 | \$1360 | 1995 | \$630 | \$2520 |
| 1983 | \$370 | \$1480 | 1996 | \$640 | \$2560 |
| 1984 | \$390 | \$1560 | 1997 | \$670 | \$2680 |
| 1985 | \$410 | \$1640 | 1998 | \$700 | \$2800 |
| 1986 | \$440 | \$1760 | 1999 | \$740 | \$2960 |
| 1987 | \$460 | \$1840 | 2000 | \$780 | \$3120 |
| 1988 | \$470 | \$1880 | 2001 | \$830 | \$3320 |
| 1989 | \$500 | \$2000 | 2002 | \$870 | \$3480 |
| 1990 | \$520 | \$2080 | 2003 | \$890 | \$3560 |

- A current year quarter may be included in the 40-quarter computation. Use the current year amount as the divisor to determine the number of quarters available.

If you need to use quarters before 1978:

- A credit was earned for each calendar quarter in which an individual was paid \$50 or more in wages (including agricultural wages for 1951-1955);
- Four credits were earned for each taxable year in which an individual's net earnings from self-employment were \$400 or more; and/or
- A credit was earned for each \$100 (limited to a total of 4) of agricultural wages paid during the year for years 1955-1977.

Social Security Administration

OMB No. 0960-0567

Consent for Release of Information

TO: Social Security Administration

| | | |
|------|---------------|------------------------|
| | | |
| Name | Date of Birth | Social Security Number |

I authorize the Social Security Administration to release information or records about me to:

| | |
|------|---------|
| NAME | ADDRESS |
| | |
| | |
| | |

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

- _____ Social Security Number
- _____ Identifying information (includes date and place of birth, parents' names)
- _____ Monthly Social Security benefit amount
- _____ Monthly Supplemental Security Income payment amount
- _____ Information about benefits/payments I received from _____ to _____
- _____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- _____ Medical records
- _____ Record(s) from my file (specify) _____
- _____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____

(Show signatures, names and addresses of two people if signed by mark.)

Date: _____

Relationship: _____

OMB NO: 0960-0575

Date of Request _____

REQUEST TO RESOLVE QUESTIONABLE QUARTERS OF COVERAGE (QC)

Complete the information below when the QC array contains either a (#) pound sign or code "Z" prior to 1978. Mail the form and a copy of the system's printout to the Social Security Administration, PO Box 17750, Baltimore, MD. 21235-0001.

Print Name: _____
Last First MI

SSN _____ - _____ - _____
Date of Birth _____ - _____ - _____
MM DD YY

Request Years

19____, 19____, 19____, 19____, 19____, 19____,
19____, 19____, 19____, 19____, 19____, 19____,
20____, 20____, 20____.

OR

19____ thru 19____, 19____ thru 19____, 19____, thru 19____,
20____ thru 20____.

State's Name & Address _____

Contact Person's Name _____
&
Telephone Number _____

The Paperwork Reduction Act of 1995 requires us to notify that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

Date of Request _____

QMB NO: 0960-0575

REQUEST FOR QUARTERS OF COVERAGE (QC) HISTORY BASED ON RELATIONSHIP

Complete the information below when requesting QC history for spouse(s) or parent (s) of a lawfully admitted non-citizen applicant. Mail the form to the Social Security Administration, PO Box 17750, Baltimore, MD 21235-0001.

Print Name: _____
Last First MI

SSN _____ - _____ - _____
Date of Birth MM - DD - YY

Relationship to Applicant _____

NOTE: COMPLETE THE YEAR COLUMN AND CIRCLE THE PERTINENT QUARTER (S) FOR THE YEAR. SSA WILL PROVIDE INFORMATION ONLY FOR YEARS AND QUARTERS YOU INDICATE.

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

State's Name _____
 &
 Address _____

Contact Person's Name _____
 &
 Telephone Number _____

| Line Item | MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS | Arrived Before August 22, 1996 | Arrived On or After August 22, 1996 | |
|-----------|---|-----------------------------------|--|----------------------|
| | | | 1 st 5 years | After 5 years |
| A | Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran] | Full Benefit A1 | Full Benefit A2 | Full Benefit A3 |
| B | Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)] | Full Benefit B1 | Emergency Only B2 | Full Benefit B3 |
| C | Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians [I-327; I-151; AR-3a; I-551; I-688B-274 a.12(a)(1)] | Full Benefit C1 | Emergency Only C2 | Emergency Only C3 |
| | | | 1 st 7 years | After 7 years |
| D | Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94] | Full Benefit D1 | Emergency Only D2 | Emergency Only D3 |
| E | Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)] | Full Benefit E1 | Emergency Only E2 | Emergency Only E3 |
| F | Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)] | Full Benefit F1 | Full Benefit F2 | Emergency Only F3 |
| G | Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)}, or Amerasians [I-551; I-94; I-688B] | Full Benefit G1 | Full Benefit G2 | Emergency Only G3 |
| H | Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge’s Order] | Full Benefit H1 | Full Benefit H2 | Emergency Only H3 |
| I | Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General] | Full Benefit I1 | Emergency Only I2 | Emergency Only I3 |
| J | Victims of a Severe Form of Trafficking pursuant to the Trafficking Victims Protection Act of 2000, P.L. 106-386 [ORR Certification/eligibility Letter] | N/A J1 | Full Benefit J2 | Emergency Only J3 |

| | UNQUALIFIED ALIEN GROUPS | Arrived Before 8-22-96 | Arrived On or After 8-22-96 | |
|---|---|---------------------------|-----------------------------------|----------------------|
| K | Aliens residing in the US pursuant to an indefinite stay of deportation [I-94; Immigration Letter] | Emergency Only K1 | Emergency Only K2 | Emergency Only K3 |
| L | Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter] | Emergency Only L1 | Emergency Only L2 | Emergency Only L3 |
| M | Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing [I-94; I-210] | Emergency Only M1 | Emergency Only M2 | Emergency Only M3 |
| N | Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing [I-181; Endorsed Passport] | Emergency Only N1 | Emergency Only N2 | Emergency Only N3 |
| O | Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing [I-94; Court Order; INS Letter] | Emergency Only O1 | Emergency Only O2 | Emergency Only O3 |
| P | Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing [I-94; I-210; I-688B – 247a.12(a)(11) or (13)] | Emergency Only P1 | Emergency Only P2 | Emergency Only P3 |
| Q | Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later [I-210; INS Letter] | Emergency Only Q1 | Emergency Only Q2 | Emergency Only Q3 |
| R | Aliens residing in the U.S. under orders of supervision [I-220B] | Emergency Only R1 | Emergency Only R2 | Emergency Only R3 |
| S | Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record] | Emergency Only S1 | Emergency Only S2 | Emergency Only S3 |

| | UNQUALIFIED ALIEN GROUPS (cont.) | Arrived Before 8-22-96 | Arrived On or After 8-22-96 | |
|--|--|--------------------------|-----------------------------|--------------------------|
| T | Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the USCIS does not contemplate enforcing [Immigration Judge Court Order] | Emergency Only T1 | Emergency Only T2 | Emergency Only T3 |
| U | Any other aliens living in the US with the knowledge and permission of the USCIS whose departure the agency does not contemplate enforcing [USCIS Contact] | Emergency Only U1 | Emergency Only U2 | Emergency Only U3 |
| V | Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired | Emergency Only V1 | Emergency Only V2 | Emergency Only V3 |
| W | Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-1186; SW-434; I-95A] | Emergency Only W1 | Emergency Only W2 | Emergency Only W3 |
| LEGAL IMMIGRANT CHILDREN UNDER AGE 19 | | | | |
| Y | Non-citizen (alien) children under the age of 19 lawfully residing in the U.S. who meet the requirements in M0220.314. | N/A | Full Benefits | Full Benefits |

| | AFGHAN AND IRAQI SPECIAL IMMIGRANTS | First 7 Years after Entry into U.S. | After 7 Years |
|---|---|-------------------------------------|--------------------------|
| Z | Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation] | Full Benefits Z1 | Emergency Only Z2 |

Proof of U.S. Citizenship and Identity for Medicaid

Effective July 1, 2006, individuals who declare on a Medicaid application that they are United States citizens must provide proof of citizenship and identity. Individuals who are already enrolled in Medicaid must provide this documentation at the time of their next Medicaid renewal.

Some common documents that may be used to meet the citizenship and identity requirement are listed below. Representatives from your local department of social services can tell you what other documents may be acceptable. If you have difficulty obtaining one of the documents listed or have any questions, please discuss your situation with your eligibility worker. Whenever possible, we will allow additional time for you to obtain the necessary documentation.

The following documents are proof of both citizenship and identity; no additional documents are necessary to meet the Medicaid requirement to provide proof of citizenship and identity.

| Document | Shows Proof Of | Issued By | Fee | For More Information, Contact |
|---|--|--|--------|--|
| U.S. Passport (unexpired or expired) | Citizenship & Identity (if issued with limitation and expired, only shows proof of identity) | U.S. Department of State | Varies | (202) 647-4000 or www.state.gov |
| Certificate of Naturalization (N-550 or N-570) | Citizenship & Identity | U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services | Varies | 1-800-375-5283 or www.uscis.gov |
| Certificate of Citizenship (N5-560 or N-561)—issued when a person was born outside U.S. to U.S. Citizen parent(s) | Citizenship & Identity | U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services | Varies | 1-800-375-5283 or www.uscis.gov |

The following documents may be used to prove citizenship only. You must also provide proof of identity.

| Document | Shows Proof Of | Issued By | Fee | For More Information, Contact |
|--|--|--|----------------------|---|
| U.S. Public Birth Record ("Birth Certificate")—must contain original embossed seal | Citizenship— (Must also provide proof of identity) | The state, commonwealth, territory or local jurisdiction | Va. Birth Cert. \$12 | For citizens born in Virginia: Department of Health, Division of Vital Records: (804) 662-6200 or www.vdh.virginia.gov (will also assist citizens born outside Virginia with finding contact information for their birth state) |

| Document | Shows Proof Of | Issued By | Fee | For More Information, Contact |
|---|---|--|----------------------|---|
| Certification of Report of Birth (FS-240); Consular Report of Birth Abroad of a Citizen of the U.S.A. (FS-545), Certification of Birth Abroad (FS-545) | Citizenship (Must also provide proof of identity) | U.S. Department of State | Varies | (202) 647-4000 or www.state.gov |
| American Indian Card (I-872) | Citizenship (Must also provide proof of identity) | U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services | Contact agency | 1-800-375-5283 or www.uscis.gov |
| Final adoption decree (or statement from state-approved adoption agency if adoption is not finalized)—must show child's name and U.S. place of birth | Citizenship (Must also provide proof of identity) | The state in which the adoption was finalized | Possible copying fee | The court issuing the decree or the adoption agency that handled the adoption |
| Evidence of Civil Services Employment by the U.S. Government—must show employment by the U.S. government before June 1, 1976 | Citizenship (Must also provide proof of identity) | U.S. Office of Personnel Management | Possible copying fee | 1-888-767-6738 or www.opm.gov |
| Official Military Record of Service—must show a U.S. place of birth (e.g. DD-214) | Citizenship (Must also provide proof of identity) | National Archives Allow 6-8 weeks | None | 1-866-272-6272 or www.veetecs.archives.gov |
| Extract of hospital record on hospital letterhead (not a "birth certificate" issued by a hospital)—must have been established at the time of birth, created at least 5 years before initial application date for Medicaid, and indicate a U.S. place of birth | Citizenship (Must also provide proof of identity) | Hospital of birth | Possible copying fee | Hospital in which individual was born |
| Life or health or other Insurance Record—must have been created at least 5 years before the initial application date for Medicaid and show a U.S. place of birth | Citizenship (Must also provide proof of identity) | Insurance Company | Possible copying fee | Insurance company that issued the policy—contact information should be listed on the policy |

| Document | Shows Proof Of | Issued By | Fee | For More Information, Contact |
|---|---|--|----------------------|-----------------------------------|
| A statement signed by the physician or midwife who was in attendance at the time of the birth—must have been created at least 5 years before the date of the initial Medicaid application and show a U.S. place of birth. | Citizenship (Must also provide proof of identity) | Physician or Midwife who delivered the individual | Possible copying fee | Physician or Midwife |
| Institutional admission papers from a nursing home or other institution or medical records—must have been created at least 5 years before the date of the initial Medicaid application and indicate a U.S. place of birth | | Nursing home or other institution in which the individual resides or resided | Possible copying fee | Nursing home or other institution |

The following documents may be used to prove identity when you provide proof of citizenship.

| Document | Shows Proof Of | Issued By | Fee | For More Information, Contact |
|---|----------------|---|----------------|--|
| Certificate of Degree of Indian Blood; other U.S. American Indian/Alaska Native or Native American tribal document—must have a photograph of individual or other personal identifying information | Identity | U.S. Department of Interior, Bureau of Indian Affairs | Contact agency | (202) 208-3100 or www.doi.gov |
| Driver's license issued by a state or territory—must have a photograph of individual or other personal identifying information | Identity | State or Territory | \$12 - \$28 | In Virginia, Division of Motor Vehicles: 1-866-368-5463 or www.dmv.virginia.gov |
| School identification (ID) card with photograph of individual | Identity | School | Contact agency | School or school district office |
| U.S. Military card or draft record; military dependent's ID card | Identity | Department of Veteran's Affairs | Contact agency | 1-800-827-1000 or www.va.gov |
| Identification card issued by federal, state, or local government with the same information included on driver's licenses | Identity | Va. Division of Motor Vehicles issues non-driver ID cards | Va. ID \$10 | 1-866-368-5463 or www.dmv.virginia.gov |

M0230 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|----------------------|
| TN #95 | 3/3/11 | pages 1, 2 |
| TN #93 | 1/1/10 | page 2 |

M0230.000 VIRGINIA RESIDENCY REQUIREMENTS**M0230.001 POLICY PRINCIPLES****A. Policy**

An individual must be a Virginia resident in order to be eligible for Medicaid, but is not required to have a fixed address. This subchapter, M0230, explains in detail how to determine if an individual is a Virginia resident.

An individual placed by a Virginia government agency in an institution is considered a Virginia resident for Medicaid purposes even when the institution is in another state (section M0230.203 below).

For all other individuals, Virginia residency is dependent on whether the individual is under age 21 years or is age 21 or older (sections M0230.201 and 202 below).

B. Retention of Residency

Residence is retained until abandoned. Temporary absence from Virginia with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Virginia residence.

C. Non-immigrant Aliens

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

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

D. Cross-Reference to Intra-State Transfer

Procedures for handling cases where individuals who are Virginia residents move from one Virginia locality to another are described in subchapter M1520.

E. No Fixed Address

The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.

For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he must come to the social services department to receive his card until he obtains a fixed address.

F. Length of Residency

The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.

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

M0230.100 DEFINITION OF TERMS

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

M0310 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|---|
| TN #95 | 3/1/11 | Pages 30, 30a |
| TN #94 | 9/1/10 | pages 21-27c, 28 |
| TN #93 | 1/1/10 | page 35 Appendix 5, page 1 |
| Update (UP) #2 | 8/24/09 | Table of Contents page 39 |
| TN #91 | 5/15/09 | pages 23-25 Appendix 4, page 1 Appendix 5, page 1 |

3. Independent Living

A foster care child who is under age 21, who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21.

4. Non-custodial and Parental Agreements

a. Non-custodial Agreement

A non-custodial agreement is an agreement between the child’s parent or guardian and the local Board of Social Services. The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.

b. Parental Agreement

A parental agreement is an agreement between the child’s parent or guardian and an agency **other than DSS** which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.

c. Placement

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child **and** the child is placed by LDSS outside the child’s home. If the LDSS has placement and care responsibility for the child and the child is placed in the child’s home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

5. Department of Juvenile Justice

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a “Department of Juvenile Justice (DJJ) child.”

B. Procedures

1. IV-E Foster Care

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments are IV-E Foster Care for Medicaid eligibility purposes. *A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother’s IV-E payment includes an allocation for her child.*

A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a “Non-IV-E Foster Care” child.

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

2. **Non IV-E Foster Care**
Children who are eligible for but do not receive IV-E maintenance payments or who are eligible for Non-IV-E (state/local) Foster Care (whether or not they receive a Non-IV-E payment), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.
3. **Non-IV-E Children in Another State’s Custody**
Children in the custody of another state’s social services agency who are not receiving IV-E foster care maintenance payments, do NOT meet the Virginia residency requirement for Medicaid (M0230) and are not eligible for Virginia Medicaid.
4. **Trial Home Visits**
A foster care or DJJ child continues to meet the foster care definition (*either IV-E or non-IV-E*) when placed by the agency in the child’s own home for a trial period of up to six months, *if the child continues to be in the agency’s custody or remains the financial responsibility of DJJ or the court*. Do not redetermine Medicaid eligibility during the 6 month trial home visit.

M0310.116 HOSPICE

A. Definition

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

1. **Hospice Care**
"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:
2. **Hospice Program**
A "hospice program" is a public agency or private organization which
 - is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
 - provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
 - meets federal and state staffing, record-keeping and licensing requirements.

M0320 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|---|
| TN #95 | 3/1/10 | pages 11, 12, 42c, 42d, 50, 53, 69 pages 70, 71 page 72 was added. |
| TN #94 | 9/1/10 | pages 49-50b |
| UP #3 | 3/1/10 | pages 34, 35, 38, 40, 42a, pages 42b, 42f |
| TN #93 | 1/1/10 | pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71 |
| UP #2 | 8/24/09 | pages 26, 28, 32, 61, 63, 66 |
| Update (UP) #1 | 7/1/09 | pages 46f-48 |
| TN #91 | 5/15/09 | pages 31-34 pages 65-68 |

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

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

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

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

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

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

4. COLA Formula

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

Note: There was no COLA in 2010 *or* 2011.

Cost-of-living calculation formula:

- a. $\frac{\text{Current Title II Benefit}}{1.058 \text{ (1/09 Increase)}} = \frac{\text{Benefit Before}}{1/09 \text{ COLA}}$
- b. $\frac{\text{Benefit before 1/09 COLA}}{1.023 \text{ (1/08 Increase)}} = \frac{\text{Benefit Before}}{1/08 \text{ COLA}}$

- 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. $\frac{\text{Benefit Before 1/06 COLA}}{1.027 \text{ (1/05 Increase)}} = \text{Benefit Before 1/05 COLA}$

Contact a Medical Assistance Program Consultant for amounts for years prior to 2005.

5. Medicare Premiums

a. Medicare Part B premium amounts:

| | |
|--------|-----------|
| 1-1-11 | \$115.40* |
| 1-1-10 | \$110.50 |
| 1-1-09 | \$96.40 |
| 1-1-08 | \$96.40 |
| 1-1-07 | \$93.50 |
| 1-1-06 | \$88.50 |
| 1-1-05 | \$78.20 |

*This amount is for individuals enrolled in Medicare on or after 1-1-11 or for individuals subject to increased Medicare premiums based on their income. The Medicare Part B premium for individuals enrolled in Medicare prior to January 1, 2010 remains \$96.40 for 2010 and 2011. The Medicare Part B premium for individuals enrolled in Medicare between January 1, 2010 and December 31, 2010 remains \$110.50 for 2011. Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.

b. Medicare Part A premium amounts:

| | |
|--------|----------|
| 1-1-10 | \$461.00 |
| 1-1-09 | \$443.00 |
| 1-1-08 | \$423.00 |
| 1-1-07 | \$410.00 |
| 1-1-06 | \$393.00 |
| 1-1-05 | \$375.00 |

Contact a Medical Assistance Program Consultant for amounts for years prior to 2005.

6. Classification

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

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

If all eligibility factors are met in the application month, eligibility for Medicaid as a QI begins the first day of the application month, **and ends December 31 of the calendar year**, if funds are still available for this covered group.

The Notice of Action on Medicaid must state the recipient's **begin and end dates** of Medicaid coverage.

E. Enrollment

1. **Aid Category** QI = 056

2. **Begin and End Dates** The begin date of coverage cannot be any earlier than January 1 of the calendar year. An edit is in place in the MMIS to prevent enrollment prior to January 1 of the current year. **Do not enter an end date of coverage.**

3. **MMIS** The MMIS will:
 - automatically cancel the QI recipient's coverage effective December 31 of each calendar year, and
 - send a notice to the recipient to reapply for Medicaid coverage for the next calendar year.

F. QI Applications & Renewals

1. **New Applicants** Applications for individuals who are not currently enrolled in Medicaid can be taken at any time. *If the application is processed in November or December, the coverage may be renewed for the following year without obtaining a separate renewal form. See M1520.200 C.11 for instructions on completing renewals for QIs.*

2. **QI Enrollees** *Coverage of individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility. See M1520.200 C.11 for instructions on completing renewals for QIs.*

G. Enrollee's Covered Group Changes To QI

1. **Before November Cut-off** An enrolled recipient's AC cannot be changed to "056" using a "change" transaction in the MMIS. If, **before November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate QI AC.

2. After November Cut-off

If, **after November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient to cancel the recipient's Medicaid coverage effective December 31. The notice must specify that he must reapply for Medicaid if he/she wants Medicaid to pay his/her Medicare Part B premium. Cancel the recipient's full coverage effective December 31, using cancel reason "007".

H. Covered Service

The eligible QI will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The QI will not receive a Medicaid card.**

**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**

Men and women who have creditable health insurance coverage are not eligible for Plan First, even when the health insurance does not cover family planning services. 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;
- *Medicare Part B*;
- 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.

MMIS will cancel coverage (cancel reason 052), and send an advance notice of the cancellation to the enrollee, in the month that it detects the following TPL:

- citizenship or alien status (M0220);
- Social Security number (M0240);
- assignment of rights (M0250);
- application for other benefits (M0270);
- institutional status (M0280).

NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.

B. IV-E Foster Care

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care maintenance payments under Title IV-E of the Social Security Act.

The child must meet the IV-E foster care definition in M0310.115 and must be receiving IV-E foster care maintenance payments. *A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.*

The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

NOTE: IV-E eligible foster care maintenance payment recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

C. IV-E Adoption Assistance

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for adoption assistance under Title IV-E of the Social Security Act and for whom a IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect.

The child must meet the IV-E adoption assistance definition in M0310.102. The child does **not** have to receive a IV-E Adoption Assistance payment in order to meet the IV-E Adoption Assistance definition.

The IV-E Adoption Assistance eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

D. Financial Eligibility

A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E *foster care* payment eligibility, *or the child's IV-E adoption assistance eligibility* via agency records.

E. Entitlement

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

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

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women with breast and cervical cancer. Virginia chose to cover this group beginning July 1, 2001.

Women eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer. *Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health.*

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Women who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These women will receive a Virginia BCCPTA application form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Women diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

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

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

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

- LIFC;
- MI Pregnant Women;
- FAMIS Plus (MI Child Under Age 19);
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage. Creditable health insurance coverage includes:

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

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, *or the woman may have a high deductible. The woman is not eligible for Medicaid in the BCCCPTA covered group because she has creditable health insurance.*

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used to screen women for this program.

Women requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

D. Application Procedures

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI

Pregnant Women, FAMIS Plus, or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), that must be initiated by a BCCEDP provider, *including those affiliated with Project Wish operating in the District of Columbia*. The application includes the BCCEDP certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

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

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

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

F. Enrollment

The aid category for BCCPTA women is "066".

G. Benefit Package

The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.

H. Renewal

Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

M0530 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|------------------------------------|
| TN #95 | 3/1/11 | page 1 Appendix 1, page 1 |
| TN #93 | 1/1/10 | pages 11, 19 Appendix 1, page 1 |

M0530.000 ABD ASSISTANCE UNIT

M0530.001 OVERVIEW

A. Introduction

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

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

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

B. Assistance Unit Composition

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

1. Responsible Relatives

a. Spouse

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

b. Parent of Blind/Disabled Child Under Age 21

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

2. SSI Recipients

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

If the SSI recipient is ineligible for Medicaid in the SSI Medicaid covered group due to excess resources, first determine the individual's eligibility in an F&C covered group, if possible, using the F&C assistance unit and financial eligibility rules. If the individual is not eligible in one of the F&C covered groups, then determine his eligibility as an ABD individual.

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

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

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

2009, 2010 and 2011: \$1,011 - \$674 = \$337

Parental Living Allowance

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

SSI payment for one person = \$674 for 2009, 2010 and 2011

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

SSI payment for both parents = \$1,011 for 2009, 2010 and 2011

Deeming Standard

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

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

2009, 2010 and 2011: \$1,011 - \$674 = \$337

Virginia DSS, Volume XIII

M0710 Changes

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|---------------------|-----------------------|--|
| TN #95 | 3/1/11 | Appendix 6, pages 1, 2 Appendix 7 |
| Update (UP) #1 | 7/1/09 | Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1 |

| MEDICALLY INDIGENT CHILD UNDER AGE 19 (FAMIS PLUS) AND PLAN FIRST INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-20-11 ALL LOCALITIES | | |
|---|-----------------------------------|-----------------------------------|
| # of persons in Family/Budget Unit | 100% FPL Monthly Limit | 133% FPL Monthly Limit |
| 1 | \$908 | \$1,207 |
| 2 | 1,226 | 1,631 |
| 3 | 1,545 | 2,054 |
| 4 | 1,863 | 2,478 |
| 5 | 2,181 | 2,901 |
| 6 | 2,500 | 3,324 |
| 7 | 2,818 | 3,748 |
| 8 | 3,136 | 4,171 |
| Each additional person add | 319 | 424 |

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

AC 080 – *Plan First for men and women with income less than or equal to 133% FPL*

| MEDICALLY INDIGENT PREGNANT WOMAN INCOME LIMITS 133% FPL EFFECTIVE 1-20-11 ALL LOCALITIES | |
|--|------------------------|
| # of persons in Family/Budget Unit | 133% FPL Monthly Limit |
| 2 | 1,631 |
| 3 | 2,054 |
| 4 | 2,478 |
| 5 | 2,901 |
| 6 | 3,324 |
| 7 | 3,748 |
| 8 | 4,171 |
| Each additional person add | 424 |

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

| TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-20-11 ALL LOCALITIES | |
|---|------------------------|
| # of Persons in Family Unit/Budget Unit | 185% FPL Monthly Limit |
| 1 | \$1,679 |
| 2 | 2,268 |
| 3 | 2,857 |
| 4 | 3,446 |
| 5 | 4,035 |
| 6 | 4,624 |
| 7 | 5,213 |
| 8 | 5,802 |
| Each additional person add | 589 |

AC 081 – LIFC one parent or caretaker in home

AC 083 – LIFC both parents in home

M0810 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|----------------------|
| TN #95 | 3/1/11 | Pages 1, 2 |
| TN #93 | 1/1/10 | pages 1, 2 |
| Update (UP) #1 | 7/1/09 | page 2 |

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 | 2011 Monthly Amount | 2010 Monthly Amount |
| 1 | \$674 | \$674 |
| 2 | 1,011 (no change in 2011) | 1,011 |
| Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them | | |
| Family Unit Size | 2011 Monthly Amount | 2010 Monthly Amount |
| 1 | \$449.33 | \$449.33 |
| 2 | 674.00 (no change in 2011) | 674.00 |

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

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

| Categorically Needy-Non Money Payment 300% of SSI | | |
|---|--------------------------------|---------------------|
| Family Size Unit | 2011 Monthly Amount | 2010 Monthly Amount |
| 1 | \$2,022 (no change in 2011) | \$2,022 |

4. Medically Needy (Effective July 1, 2009)

| a. Group I | | |
|------------------|-------------|----------|
| Family Unit Size | Semi-annual | Monthly |
| 1 | \$1,684.75 | \$280.79 |
| 2 | 2,145.14 | 357.52 |
| b. Group II | | |
| Family Unit Size | Semi-annual | Monthly |
| 1 | \$ 1,943.94 | \$323.99 |
| 2 | 2,394.04 | 399.00 |
| c. Group III | | |
| Family Unit Size | Semi-annual | Monthly |
| 1 | \$2,527.13 | \$421.18 |
| 2 | 3,047.07 | 507.84 |

5. ABD Medically Indigent

**For:
ABD 80% FPL,
QMB, SLMB, &
QI with or
without Social
Security income,
QDWI and
MEDICAID
WORKS,
effective 1/20/11**

| | | |
|---|----------|---------|
| ABD 80% FPL | Annual | Monthly |
| 1 | \$8,712 | \$726 |
| 2 | 11,768 | 981 |
| QMB 100% FPL | Annual | Monthly |
| 1 | \$10,890 | \$908 |
| 2 | 14,710 | 1,226 |
| SLMB 120% of FPL | Annual | Monthly |
| 1 | \$13,068 | \$1,089 |
| 2 | 17,652 | 1,471 |
| QI 135% FPL | Annual | Monthly |
| 1 | \$14,702 | \$1,226 |
| 2 | 19,859 | 1,655 |
| QDWI and MEDICAID WORKS 200% of FPL | Annual | Monthly |
| 1 | \$21,780 | \$1,815 |
| 2 | 29,420 | 2,452 |

S0820 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|-----------------------------------|
| TN #95 | 3/1/11 | pages 3, 30, 31 |
| TN #93 | 1/1/10 | pages 30, 31 |
| TN #91 | 5/15/09 | Table of Contents pages 29, 30 |

WAGES

S0820.100 GENERAL

A. Definition

Wages are what an individual receives (before deductions) for working as someone else's employee.

NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages (e.g., ministers, real estate agents, sharefarmers, *newspaper vendors*, etc.). *An S Corporation may pay wages to an individual who performs work-related services and is considered an employee of the S Corporation (i.e. President), even if the individual is a shareholder of the S Corporation.*

B. Policy

1. Kinds of Wages

Wages may take the form of:

- a. **Salaries**--These are payments (fixed or hourly rate) received for work performed for an employer.
- b. **Commissions**--These are fees paid to an employee for performing a service (e.g., a percentage of sales).
- c. **Bonuses**--These are amounts paid by employers as extra for past employment (e.g., for outstanding work, length of service, holidays, etc.)
- d. **Severance pay**--This payment made by an employer to an employee whose employment is terminated independently of his wishes.
- e. **Military basic pay**--This is the service member's wages, which is based solely on the member's pay grade and length of service. See S0830.540 C.3.
- f. **Special payments received because of employment.**
- g. **Sick pay received within 6 months after stopping work, which is not attributable to the employee's contribution**--See S0820.005

2. When To Count

Wages for each month count at the earliest of the following points:

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

C. Procedure

Absent evidence to the contrary, if FICA taxes have been deducted from an item, assume it meets the definition of wages. If FICA taxes have not been deducted from an item, determine if it is wages per S0820.102.

D. References

- Work related unearned income, S0830.530.
- Advance dated checks, S0810.030 B.2.
- Wage advances and deferred wages, S0820.115.

3. Other Earned Income

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

- a. Federal earned income tax credit payments.
- b. Up to \$10 of earned income in a month if it is infrequent or irregular.
- c. For 2010 and 2011, up to \$1,640 per month, but not more than \$6,600 in a calendar year, of the earned income of a blind or disabled student child.
- d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month.
- e. \$65 of earned income in a month.
- f. Earned income of disabled individuals used to pay impairment-related work expenses.
- g. One-half of remaining earned income in a month.
- h. Earned income of blind individuals used to meet work expenses.
- i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

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

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

6. Couples

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

B. References

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

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

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

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

- 1. General** For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.
- | For Months | Up to per month | But not more than in a calendar year |
|---------------------------------|------------------------|---|
| In calendar years 2010 and 2011 | \$1,640 | \$6,600 |
- 2. Qualifying for the Exclusion** The individual must be:
- a child under age 22; and
 - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility** Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases** The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

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

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

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S1110 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|-----------------------------|
| TN #95 | 3/1/11 | page 2 |
| Update (UP) #3 | 3/2/10 | Table of Contents page 2 |
| TN #93 | 1/1/10 | page 2 |
| TN #91 | 5/15/09 | pages 14-16 |

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

| ABD Eligible Group | One Person | Two People |
|---|-------------------|-------------------|
| Categorically Needy Cat-Needy Non-money Payment Medically Needy | \$2,000 | \$3,000 |
| ABD With Income \leq 80% FPL | \$2,000 | \$3,000 |
| QDWI | \$4,000 | \$6,000 |
| QMB SLMB QI | \$6,680 | \$10,020 |

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from \$3,000 to \$2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

S1130 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|---------------------------------|
| TN #95 | 3/1/11 | pages 28, 29, 33 |
| TN #94 | 9/1/10 | pages 20, 20a, 28-29a |
| TN #93 | 1/1/10 | pages 63-65 pages 70, 74, 75 |
| TN #91 | 5/15/09 | page 13 |

They usually include, for example: transportation of the body, embalming, cremation, flowers, clothing, services of the funeral director and staff, etc.

b. Expenses Not Included

Usually, expenses for items used for interment of the deceased's remains are not included for burial funds exclusion purposes. Such items may be subject to the burial space exclusion (**M1130.400**). However, items that do not qualify for the burial space exclusion, e.g., a space being purchased by installment contract, may be excluded under the burial fund exclusion.

C. Policy--General

1. Amount of Funds That Can Be Excluded

a. Maximum Exclusion

We can exclude up to \$3,500 each in funds set aside for:

- the burial expenses of the individual; and
- the burial expenses of the individual's spouse (eligible or ineligible) .

This exclusion is separate from and in addition to the burial space exclusion.

Funds paid on an installment contract do **NOT** qualify for the **burial space exclusion**.

Funds paid on an installment contract for burial spaces may qualify for the burial fund exclusion.

b. Reductions in Maximum Exclusion

The maximum \$3,500 that can be excluded from countable resources is reduced by:

- the face value of life insurance (not including term policies) owned by and insuring the individual and/or the individual's spouse, if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual aged 21 or over does not exceed \$1,500), and
- the face value (not including the value of burial space items) of an irrevocable burial trust established before 8/11/93 *or other irrevocable arrangement specifically designated for the purpose of meeting the individual's or spouse's burial expenses*, regardless of whether the arrangement is owned by the individual or someone else, and
- the face value of burial insurance, regardless of whether the burial insurance is owned by the individual or someone else, and

- the face value of burial contracts (not counting the value of burial space items), regardless of whether the contract is owned by the individual or someone else.

c. Exceptions Related to Huff-Cook/Settlers Policies

Huff-Cook Mutual Burial Association life insurance policies (which may be designated as Care Plans on the policy) sold prior to April 7, 1993 **do not reduce** the \$3,500 burial fund exclusion.

Huff-Cook life insurance policies sold from April 7, 1993 through November 30, 1993 **reduce** the burial fund exclusion.

Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 **do not reduce** the \$3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

d. EXAMPLE – Burial Fund Exclusion

Mrs. Brown has the following burial resources:

\$2,000 designated savings account
\$ 200 irrevocable burial contract

\$3,500 maximum exclusion
- 200 irrevocable burial contract
\$3,300 available exclusion
-2,000 excluded burial funds
\$1,300 still available for exclusion

Treatment - We exclude the \$2,000 savings account. Two years later, Mrs. Brown wants to add to her designated burial savings account, which now has a balance of \$2,150 due to accumulated interest. She can increase the amount of excluded funds in the account by up to \$1,300. Note that when determining the amount still available for burial fund exclusion, we disregard the amount of interest which accumulated in the account.

e. Subsequent Purchase of Excluded Life Insurance or Irrevocable Burial Contract

A subsequent purchase of an excluded life insurance policy or an irrevocable burial contract reduces the amount of the available burial funds exclusion as described in b. above. The reduction is effective the month after the month in which the life insurance or the irrevocable burial contract was purchased.

f. Burial Insurance

Burial insurance policies are not life insurance policies (see **M1130.300** for a definition of burial insurance). For Medicaid purposes, burial insurance is an irrevocable arrangement whose face value reduces the maximum burial funds exclusion by the policy's face value.

Exceptions: Huff-Cook Mutual Burial Association life insurance policies sold prior to April 7, 1993 do not reduce the \$3,500 burial fund exclusion.

- 2. Verify Form and Separation of Funds** Verify that the funds meet the definition of burial funds in B.1. above and that the funds are separated from all other non-burial-related assets (C.3. above). Burial funds must meet both of these requirements before we can exclude them. If funds cannot be excluded, tell the individual why (e.g., if the funds are not separate from non-burial assets).
- 3. Determine Date Funds Set Aside for Burial** If an individual alleges having set aside funds for burial, determine the date they were first considered as set aside and document the file with supporting evidence.
- If the funds are already clearly designated (e.g., by the title of a savings account), accept any official record which shows the title of the account and which establishes that the designation was in effect prior to the month of application.
 - If the funds are **not** already clearly designated, obtain the statement described in D. above.
 - See D.4. above regarding effective date of the exclusion for funds considered set aside for burial prior to filing.
- 4. Verify Value of Funds** Verify the value of any burial funds to be excluded, using the instructions that apply to the specific resources in question.
- 5. Determine Amount of Exclusion Available** Document the file with evidence of:
- the face value of life insurance owned by and insuring the individual or the individual's spouse if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual age 21 or over does not exceed \$1,500), and
 - the face value (not including the value of burial space items) of an irrevocable burial trust established before 8/11/93 *or other irrevocable arrangement specifically designated for the purpose of meeting the individual's or spouse's burial expenses*, regardless of whether the arrangement is owned by the individual or someone else, and
 - the face value of burial insurance whether owned by the individual or someone else, and
 - the face value of burial contracts (not counting the value of burial space items) whether the contract is owned by the individual or someone else.

Should the \$3,500 maximum exclusion be reduced by life insurance, any irrevocable arrangement including an irrevocable burial trust established before 8/11/93, burial insurance, or a burial contract, document the amount by which the exclusion will be reduced, including the computation of the amount. To make this computation, you may use the electronic Burial Funds Exclusion Worksheet located on the VCU-VISSTA website:

http://www.vcu.edu/vissta/bps/bps_resources/medicaid/abd_medicaid/master_bfe_worksheet.xls

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M1310 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|----------------------|
| TN #95 | 3/1/11 | page 4 |

13. Initial Application An initial application is the individual’s first Medicaid MN spenddown application. There are two ways an individual can have an initial application:

- this is the individual’s first application for Virginia Medicaid, or
- this is the first time the individual has been placed on a spenddown.

14. Legally Responsible Relative A legally responsible relative is the individual’s spouse and/or, when the individual is under age 21, a parent who is responsible by law to support the individual. The legally responsible relative’s resources and income may be used in determining the individual’s Medicaid eligibility.

15. Liable Third Party Liable third party means any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease or disability of a Medicaid applicant or recipient.

16. Medical Expense Record Form The “Medical Expense Record-Medicaid” (#032-03-023) is a form provided to the client for keeping a chronological record of his medical expenses. It is used by the eligibility worker to determine if the spenddown has been met.

17. Medically Needy Income Limit (MNIL) MNIL means the medically needy income limit. This is the income standard established to determine the financial eligibility of medically needy individuals and families.

18. Noncovered Expenses Noncovered expenses are expenses for necessary medical and remedial services recognized under state law but not covered under the Medicaid State Plan, including those that exceed the Medicaid limitation on amount, duration, or scope of the service covered under the State Plan.

19. Old Bills Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application’s retroactive period
or
- *were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and*
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

Old bills that are based on previous applications do not meet the definition of “old bills” when there has been a break in spenddown eligibility.

EXCEPTION: Bills paid by a state or local program are treated as old bills even though they are not the individual’s liability.

20. Prospective Budget Period A prospective budget period is the prospective period of time during which income is projected for the purpose of determining spenddown eligibility.

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M1320 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|----------------------|
| TN #95 | 3/1/11 | page 1 |

M1320.000 SPENDDOWN INFORMATION

M1320.100 INFORMING THE APPLICANT

A. Introduction

An individual applicant who meets all the medically needy Medicaid eligibility requirements except income, because his countable income exceeds the Medicaid income limits, must be told about spenddown and what he can do to become eligible for Medicaid coverage for a limited time period.

This section lists the items of which the EW must inform the applicant.

B. Allowable Expenses

The worker must inform the applicant about the incurred medical, dental, or remedial care expenses, either paid or unpaid, that can be deducted from the spenddown liability.

1. Covered By State or Local Public Program

Expenses for incurred medical services received on or after December 22, 1987, which were provided, covered, or paid for by a state or local government program can be deducted even though the applicant does not owe anything for the service.

Expenses covered by Medicare and Medicaid (which are federal programs) CANNOT be deducted.

2. Old Bills

Expenses incurred for medical services received prior to the initial application's retroactive period or *during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources)* may be deducted if:

- the applicant is legally liable to pay the expense;
- the applicant still owes a balance to the medical service provider for the service;
- the expense was not deducted from (counted in) any previous spenddown budget period in which the spenddown was met, and
- a claim for the expense was submitted to the liable third party(ies), if any.

3. Third Party Payment

An allowable medical expense cannot be deducted until the individual's insurance or other third party, if applicable, has taken action on the claim and the applicant provides evidence documenting:

- the claim was denied, or
- the amount of the claim paid by the third party.

Only the amount not covered by the third party(ies) and which remains the liability of the individual may be deducted from the spenddown liability.

M1340 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|----------------------|
| TN #95 | 3/1/11 | page 6 |
| TN #94 | 9/1/10 | page 6 |
| TN #93 | 1/1/10 | page 18 |

1. **Beneficiary NOT In Medicare PDP on Date of Service**
If the Medicare beneficiary was not enrolled in a Medicare PDP on the date of the prescription drug service, allow the prescription drug cost that is the responsibility of the beneficiary as a spenddown deduction.
2. **Beneficiary in Medicare PDP on Date of Service**
If the Medicare beneficiary was enrolled in a Medicare PDP on the date of service, allow the prescription drug cost (deductible, co-pays and/or coverage gap) that is the responsibility of the beneficiary as a spenddown deduction.
3. **PDP Denies Drug Coverage**
If a Medicare PDP denies coverage of a prescription drug, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.
 - Do NOT allow the charge if the drug charge appears on the statement as a denial and no exception was requested.
 - Allow the charge if the drug charge appears on the statement as a denial, and an exception was requested and denied.

Medicare beneficiaries who are enrolled in a Medicare PDP should be advised to keep their statements and other related documentation for consideration under spenddown.

M1340.600 OLD BILLS

- A. Policy**
- Old bills are any unpaid medical, dental and/or remedial care expenses incurred prior to the retroactive period based on an initial application. Unpaid medical, remedial, and dental care expenses incurred prior to a re-application and its retroactive period may also be deducted as old bills provided that:
- they were not incurred during a prior spenddown budget period, in which spenddown eligibility was established, *or*
 - *they were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and*
 - they were not fully deducted from any previous spenddown that was met, and
 - they remain the liability of the individual.

Old bills may include medical bills that were paid by a state or local program.

An unused portion of an old bill which is still the liability of the individual may be applied to a future consecutive spenddown budget period(s) only if there is no break in spenddown eligibility. If there is a break in spenddown eligibility, only current payments made on old bills based on a prior spenddown application can be deducted in the current budget period. The old bill from a prior application is no longer an “old bill” as defined in section M1310.300. Only the amount of any “current payment” made on that expense in the current budget period can be deducted. Go to section M1340.800 for current payments policy and procedures.

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M1410 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|--------------------------------------|
| TN #95 | 3/1/11 | Pages 13, 14 Page 15 was removed. |
| TN #94 | 9/1/10 | pages 6, 7, 13 |
| TN #93 | 1/1/10 | pages 1, 7, 9, 12 |
| TN #91 | 5/15/09 | pages 11-14 |

b. Where to Send the DMAS-225

- 1) For hospice services patients, *including hospice patients in a nursing facility or those who are also receiving CBC services*, send the original form to the hospice provider.
- 2) For facility patients, send the original form to the nursing facility.
- 3) For PACE or *adult day health care* recipients, send the original form to the PACE or *adult day health care* provider.
- 4) For Medicaid CBC, send the original form to the following individuals
 - the case manager at the Community Services Board, for the *ID/MR* and *DS* waivers;
 - the case manager (support coordinator), for the *DD Waiver*,
 - the personal care provider, for agency-directed *EDCD* personal care services and other services. *If the patient receives both personal care and adult day health care, send the DMAS-225 to the personal care provider.*
 - the service facilitator, for consumer-directed *EDCD* services,
 - the case manager, for any enrollee with case management services, and
 - the case manager at *DMAS*, for the *Tech Waiver*, at the following address:

Department of Medical Assistance Services
Division of LTC, Waiver Unit,
600 E. Broad St,
Richmond, VA 23219.

Retain a copy of the completed *DMAS-225* in the case record.

4. Advance Notices of Proposed Action

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

a. Advance Notice of Proposed Action (#032-03-0018)

The Advance Notice of Proposed Action, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, must be used when:

- eligibility for Medicaid will be canceled,
- eligibility for full-benefit coverage Medicaid changes to *QMB*, *SLMB*, or *QWDI* limited coverage, or

- Medicaid payment for LTC services will be terminated because of an asset transfer.

b. Notice of Obligation for Long-Term Care Costs

When a change in the patient pay amount is entered in MMIS, a “Notice of Obligation for Long-term Care Costs” will be generated and sent by MMIS as the advanced notice to the recipient or the authorized representative.

Patient pay must be entered into MMIS no later than close-of-business on the 15th day of the month, to meet the advance notice requirement.

Do not send the “Advance Notice of Proposed Action” when patient pay increases.

5. Medicaid Redetermination For Long-term Care (#032-03-0369)

The Medicaid Redetermination for Long-term Care Form is used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

The Medicaid Redetermination for Long-Term Care Form is available on SPARK at:

http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

M1450 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|---|
| TN #95 | 3/1/11 | pages 4, 24,32, 36, 37, 37a, pages 39, 42, 43 |
| TN #94 | 9/1/10 | Table of Contents pages 36-37a, 39-44 |
| TN #93 | 1/1/10 | Table of Contents pages 3, 17-18, 29 Appendix 2, page 1 |
| TN #91 | 5/15/09 | pages 41, 42 |

are housed in an area certified as a nursing facility or intermediate care facility for the mentally retarded; or

- a Medicaid applicant/recipient who has been screened and approved for or is receiving Medicaid community-based care (CBC) waiver services, *services through the Program of All Inclusive Care for the Elderly (PACE) or hospice services.*

H. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over \$500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

1. Parties Legally Competent

The parties to the contract were legally competent to enter into the contract. (Generally, this excludes (1) individuals declared to have mental incapacity or a diminished mental capacity and (2) children less than 18 years of age, who may not enter into a contract under Virginia law. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract).

2. Valuable Consideration

“Valuable consideration” is received by each party when the “adequate compensation” requirement for the asset transfer rule is met.

3. Definite Contract Terms

Contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. For example, it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.

4. Mutual Assent

Contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

I. Look-Back Date

The **look-back date** is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers that take place on or after the look-back date. Penalties cannot be imposed for transfers that take place before the look-back date.

1. Transfers Made Before February 8, 2006

- In the case of a **revocable trust**, any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for less than fair market value as of the date the payment was made. The look back date is 60 months before the baseline date.
- In the case of an **irrevocable trust from which payment can be made to the individual**, any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for

When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

M1450.570 SERVICES CONTRACTS

- A. Policy** Services contracts (i.e. personal care contract, care contracts, etc.) are typically entered into for the completion of tasks such as, but not limited to, grocery shopping, house keeping, financial management and cooking, that individuals no longer can perform for themselves. For purposes of Medicaid payment of LTC services, payments made under these types of contracts may be considered an uncompensated transfer of assets.
- B. Procedures** When a services contract, sometimes referred to as a personal care contract, is presented as the basis for a transfer of assets, the eligibility worker must do the following:
- 1. Determine Institutionalization** Determine when the individual met the requirement for institutionalization.
 - 2. Verify Contract Terms and Value of Services** Obtain a copy of the written contract, or written statements verifying the terms of the agreement by all parties. Determine when the agreement was entered into/signed, who entered into/signed the contract and if the contract is legally binding as defined by policy at M1450.003 H. The terms of the contract must include the types of services, *hourly* rate of payment and the number of hours for each service. *The hourly rate for the services must be the fair market value for such services at the time the services were provided.* The terms must be specific and verifiable. Verification of payments made and services provided must be obtained. Any payment for a service which does not have a fair market value is an uncompensated transfer.
 - 3. Contract Services Must Be Received Before Admission to LTC** A contract for services may have been created prior to or after the individual's entrance into LTC. Once an individual begins receipt of Medicaid LTC services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.
 - 4. Physician Statement Required** A statement must be provided by the individual's physician that indicates the types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.
 - 5. Contract Made By Individual or Authorized Representative** The contract must have been made by the applicant/recipient or his authorized representative.

For recipients of Medicaid who transfer an asset while receiving Medicaid, the penalty date is **the first day of the month FOLLOWING the month** in which the asset transfer occurred, provided that date does not occur during an existing penalty period.

C. Penalty Period Calculation

The penalty period is the number of months calculated by dividing the uncompensated value of the assets transferred on or after the look-back date, by the average monthly cost of nursing facility services to a private patient **at the time of application for Medicaid**. Beginning 10-1-97, the average cost differs for individuals in the following Northern Virginia localities: Arlington, Fairfax, Loudoun and Prince William counties and the cities of Alexandria, Fairfax, Falls Church, Manassas and Manassas Park. The average cost is determined based on the locality in which the **individual is physically located at the time of application for Medicaid**.

See the chart below for the average private nursing facility cost for the Northern Virginia localities and all other Virginia localities effective October 1, 1996.

D. Average Monthly Private Nursing Facility Cost

| <u>Application Date</u> | <u>Average Monthly Private Nursing Facility Cost*</u> | |
|-------------------------|---|-----------------------------|
| | <u>Northern Virginia</u> | <u>All Other Localities</u> |
| 10-1-96 to 9-30-97 | \$2,564 | \$2,564 |
| 10-1-97 to 12-31-99 | \$3,315 | \$2,585 |
| 01-01-00 to 12-31-00 | \$3,275 | \$2,596 |
| 01-01-01 to 12-31-01 | \$4,502 | \$3,376 |
| 01-01-02 to 12-31-03 | \$4,684 | \$3,517 |
| 01-01-04 to 9-30-07 | \$5,403 | \$4,060 |
| 10-1-07 to 12-31-10 | \$6,654 | \$4,954 |
| 01-01-11 and after | \$7,734 | \$5,933 |

*Figures provided by Virginia Health Information.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. One Transfer

1. Determine the penalty period:
 - divide the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid;
 - round the result down;
 - the result is the number of months in the penalty period.
2. Determine the penalty date.
3. Beginning with the penalty date, count the number of months in the penalty period to the end of the period.
4. The last day of the last month in the penalty period is the end date of the penalty period.

EXAMPLE #14: Mr. D. a 67 year old widower who lives in his own home applies for Medicaid on October 1, 1996. He is found eligible for retroactive and ongoing Medicaid.

- 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

When a transfer of assets on or after February 8, 2006, affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTC services if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

Individuals in a penalty period who meet all other Medicaid eligibility requirements may be eligible for Medicaid payment for all other Medicaid covered services.

B. Penalty Begin Date

For individuals not receiving LTC services at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTC services at the time of transfer, the penalty period begins the month following the month of transfer.

1. **Medicaid LTC Not Received at Time of Transfer** If the individual is not receiving Medicaid-covered LTC services at the time of the asset transfer, the penalty period begins on the date the individual is eligible for Medicaid and would otherwise be eligible for the Medicaid payment of LTC services but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

 2. **Receiving Medicaid LTC Services at Time of Transfer** *If the individual is receiving Medicaid LTC services at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred. A referral to the DMAS Recipient Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTC services. See Chapter M17 for instructions on RAU referrals.*

 3. **Penalty Periods Cannot Overlap** When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

 4. **Nursing Facility** If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

 5. **CBC, PACE, Hospice** If the individual has been screened and approved for or is receiving Medicaid CBC, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTC services in any other covered group. *The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTC services, or (3) he is admitted to a nursing facility.*
- C. Penalty Period Calculation** The penalty period is the number of months, including any fractional portion of a month that an individual will be ineligible for the Medicaid payment of LTC services.
- The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).
- When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.
- D. Average Monthly Nursing Facility Cost** See M1450.620.D for the average monthly nursing facility cost for the locality in which the individual is physically located at the time of application for Medicaid.
- E. Partial Month Transfer** The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.

Example #19: An individual makes an uncompensated asset transfer of \$30,534 in April 2006, the same month he applies for Medicaid. The uncompensated value of \$30,534 is divided by the average monthly rate of \$4,060 and equals 7.52 months. The full 7-month penalty period runs from April 2006, the month of the transfer, through October 2006, with a partial penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount (\$2,114) by the daily rate. The calculations are as follows:

Step #1 \$30,534.00 uncompensated value of transferred asset
 \div 4,060.00 avg. monthly nursing facility rate at time of application
 = 7.52 penalty period (7 full months, plus a partial month)

Step #2 \$ 4,060.00 avg. monthly nursing facility rate at time of application
 \times 7 seven-month penalty period
 \$28,420.00 penalty amount for seven full months

Step #3 \$30,534.00 uncompensated value
 $-$ 28,420.00 penalty amount for seven full months
 \$ 2,114.00 partial month penalty amount

**C. Example #21
Partial
Compensation
Received**

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth \$40,000 to her son and received no compensation in return for the property. Ms. H's Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H's son paid her \$20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of \$20,000 and a penalty period of 4 months, beginning October 1, 2004, and continuing through January 31, 2005.

The \$20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. An undue hardship may exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life. An undue hardship may be granted when documentation is provided that shows:

- that the assets transferred cannot be recovered, and
- that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

Applicants, recipients, or authorized representatives may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

A claim of undue hardship:

- *can be made for an individual who meets all Medicaid eligibility requirements and is subject to a penalty period.*
- *cannot be made on a denied or closed Medicaid case.*
- *cannot be used to dispute the value of a resource.*

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances

informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. If additional *information* is needed to support or clarify the documentation received with the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation. A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims

If DMAS is unable to *approve an undue hardship request because sufficient supporting documentation was not submitted, the claim must be denied. Once a claim is denied*, no further decision related to the same *asset transfer* will be made by DMAS, should the individual reapply for Medicaid coverage of LTC services.

M1450.800 AGENCY ACTION

A. Policy

If an individual's asset transfer is not allowable by policy, the individual is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for the Medicaid payment of long-term care services, *as well as his eligibility or ineligibility for Medicaid per M1450.810 below.*

B. Procedures

The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

A. Policy

Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the notice to the individual must contain the following:

1. Notice Includes Penalty Period

The form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.

2. Individual In Facility - Eligible

An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for LTC services.

3. Individual Not in Facility - Not Eligible

An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered CBC services, *PACE or hospice services*. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

B. Notice Contents

The Notice of Action on Medicaid sent to the individual must specify that:

- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred on (date/dates);
- the penalty period may be shortened if compensation is received.

The notice must also specify that either:

- the individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); **or**
- the individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.

C. Advance Notice

When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify that either:

- *The individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); **or***
- *The individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.*
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
- The penalty period may be shortened if compensation is received.

M1450.820 PROVIDER NOTICE

A. Introduction

Use the Medicaid LTC Communication Form (DMAS-225) to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

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M1460 Changes

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|---------------------|-----------------------|----------------------|
| TN #95 | 3/1/11 | pages 3, 4, 35 |
| TN #94 | 9/1/10 | page 4a |
| TN #93 | 1/1/10 | pages 28, 35 |
| TN #91 | 5/15/09 | pages 23, 24 |

10. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

11. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

12. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. *This includes individuals who filed reapplications after a break in Medicaid eligibility.* It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

If a Medicaid applicant or enrollee was approved for LTC on or after July 1, 2006, the substantial home equity must be evaluated immediately and appropriate action taken if the individual has substantial home equity.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds *the limit* are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Home Equity Limit

The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- *Effective January 1, 2006 through December 31, 2010: \$500,000*
- *Effective January 1, 2011: \$506,000.*

2. **Reverse Mortgages** Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.
3. **Home Equity Credit Lines** A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.
- C. **Verification Required** Verification of the equity value of the home is required.
- D. **Notice Requirement** If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding *the limit*, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.
- E. **References** See section M1120.225 for more information about reverse mortgages.

M1460.160 LONG-TERM CARE PARTNERSHIP POLICIES

- A. **Introduction** A Long-term Care Partnership Policy (Partnership Policy) is a type of LTC insurance. Under section 6021(a)(1)(A) of the Deficit Reduction Act (DRA) of 2005 states were permitted to develop LTC partnerships. In addition to paying for assisted living or long-term care services, a Partnership Policy allows for additional assets to be disregarded in the Medicaid eligibility determination.
- The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of the policy.
- The Partnership Policy disregard is not applicable to the resource assessment for married individuals with a community spouse. See M1480 for more information regarding resource assessments and Partnership Policies.
- B. **LTC Insurance Policy Issued Prior to 9/01/2007** LTC policies issued prior to 9/01/2007 are **not** Partnership Policies. See M1470.230 B.6, M1470.430 B.5 and M1470.820 D for more information regarding these types of insurance policies.
- C. **LTC Insurance Policy Issued on or After 9/01/2007** LTC policies issued on or after 9/01/2007 may or may not be Partnership Policies. For a policy to be considered a Partnership Policy, it must meet the following conditions:
- issued on or after 09/01/2007,
 - contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and

6. **Domestic Travel Tickets** Gifts of domestic travel tickets [1612(b)(15)].
7. **Victim's Compensation** Victim's compensation provided by a state.
8. **Tech-related Assistance** Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].
9. **\$20 General Exclusion** \$20 a month general income exclusion for the unit.
EXCEPTION: Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.
10. **PASS Income** Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].
11. **Earned Income Exclusions** The following earned income exclusions are not deducted for the 300% SSI group:
- a. In 2010 and 2011, up to \$1,640 per month, but not more than \$6,600 in a calendar year, of the earned income of a blind or disabled student child
 - b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].
 - c. \$65 of earned income in a month [1612(b) (4)(C)].
 - d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].
 - e. One-half of remaining earned income in a month [1612(b) (4)(C)].
 - f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].
 - g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].
12. **Child Support** Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

M1470 Changes

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|---------------------|-----------------------|--|
| TN #95 | 3/1/11 | pages 9, 19, 20, 23 |
| TN #94 | 9/1/10 | Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31 |
| TN #93 | 1/1/10 | pages 9, 13, 19-20, 23, 43, 44 |
| TN #91 | 5/15/09 | Table of Contents pages 1-56 Appendix 1 |

prescription drug plan (PDP) with a “benchmark” premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full-benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual’s responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2011 is \$33.25.

6. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month’s patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

**C. Non-covered
Medical/Dental
Services**

Deductions for the cost of a patient’s medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient’s income.

Services that are covered by Medicaid in the facility’s per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

**1. Zero Patient
Pay
Procedures**

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance (PMA). The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

a. Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver and Day Support (DS) Waiver

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- EDCD Waiver,
- ID/MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

The PMA is:

- January 1, 2011 through December 31, 2011: \$1,112 (no change for 2011)
- January 1, 2010 through December 31, 2010: \$1,112.

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2009.

b. AIDS Waiver

Patients under the AIDS waiver are allowed a monthly basic PMA that equals 300% of the SSI payment limit for one person (see M0810.002 A. 3).

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee.

The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance for Recipients in EDCD, DD, ID/MR or DS Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022 *in 2011*) per month.
- b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348 *in 2011*) per month.

4. Example – Special Earnings Allowance (Using January 2009 figures)

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$928.80) to the 200% of SSI maximum (\$1,348.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\$ 1,112.00 CBC basic maintenance allowance
+ 928.80 special earnings allowance
\$ 2,040.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to \$2,022.00.

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.
- The result is the dependent child allowance. If the result is greater than \$0, deduct it from the patient's income as the dependent child allowance. If the result is \$0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home.

Do not deduct an allowance for any other family member.

For cash assistance and QMB (either just QMB or dually-eligible) enrollees, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

**2. Example -
Medicare Buy-
in (Using
January 2009
Figures)**

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is \$1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually \$1596.40. He is CNNMP eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CNNMP. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

**3. Medicare Part
D Premiums**

The federal government sets a yearly "benchmark" premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP) with a "benchmark" premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2011 is \$33.25.

M1480 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|---|
| TN #95 | 3/1/11 | pages 7-9, 13, 18a, 18c, 66, pages 69, 70 |
| TN #94 | 9/1/10 | pages 64, 66, 69, 70 |
| TN #93 | 1/1/10 | Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 31, 50, 51, 66, pages 69, 70, 93 Appendix 4 was removed. |
| Update (UP) #1 | 7/1/09 | page 66 |
| TN # 91 | 5/15/09 | pages 67, 68 pages 76-93 |

27. **Spousal Share** means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.
28. **Spouse** means a person who is legally married to another person under Virginia law.
29. **Waiver Services** means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

- A. Applicability** The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. *This includes individuals who filed reapplications after a break in Medicaid eligibility.* It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

If a Medicaid applicant or enrollee was approved for LTC on or after July 1, 2006, the substantial home equity must be evaluated immediately and appropriate action taken if the individual has substantial home equity.

- B. Policy** Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds *the limit* are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by
- a spouse,
 - a dependent child under age 21 years, or
 - a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. **Home Equity Limit** *The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:*
- *Effective January 1, 2006 through December 31, 2010: \$500,000*
 - *Effective January 1, 2011: \$506,000.*
2. **Reverse Mortgages** Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

- 3. Home Equity Lines of Credit** A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received
- B. Verification Required** Do not assume that the community spouse is living in the home. Obtain a statement from the applicant indicating who lives in the home. If there is no spouse, dependent child under age 21, or blind or disabled child living in the home, verification of the equity value of the home is required.
- C. Notice Requirement** If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding *the limit*, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.
- D. References** See section M1120.225 for more information about reverse mortgages.

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Virginia DSS, Volume XIII, Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months; and
- up to **\$1,500** of burial funds for each spouse (NOT \$3,500), *if there are designated burial funds.*

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy).

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been screened and approved to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy

1. Resource Assessment

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **\$1,500** of burial funds for each spouse (NOT \$3,500), *if there are designated burial funds*.

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide to the EW a letter indicating the following:

- *the applicant is requesting an undue hardship evaluation;*
- the name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative;
- the length of time the couple has been separated;
- the name of the estranged spouse and his
 - date of birth,
 - Social Security number,
 - last known address,
 - last known employer,
 - the types (i.e. telephone, in-person visit) and number of attempts made to contact the separated spouse:
 - who made the attempt, the dates the attempts were made,
 - the name of the individual contacted and relationship to estranged spouse; and
- any legal proceeding initiated, protective orders in effect, etc.

2) Eligibility Worker

A cover sheet is to be prepared that includes the following information:

- the applicant's name, case number, and
- documentation of any actions the EW took to locate or contact the estranged spouse.

The cover sheet and all information supporting the undue hardship claim must be sent to:

Division of Policy and Research, Eligibility Section
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines that undue hardship does exist, the EW will be sent instructions for continued processing of the case as well as the DMAS Affidavit and Assignment forms, which the applicant or his representative must sign, have notarized and return to the agency.

2. After Eligibility is Established Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse’s resources when determining the institutionalized spouse’s Medicaid eligibility. Do not count or deem the community spouse’s resources available to the institutionalized spouse.

If an institutionalized spouse’s Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

C. Institutionalized Spouse Resource Eligibility Worksheet Use the “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm to determine the institutionalized spouse’s resource eligibility.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse’s initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard \$21,912 *1-1-11 (no change for 2011)*
 \$21,912 1-1-10

C. Maximum Spousal Resource Standard \$109,560 *1-1-11 (no change for 2011)*
 \$109,560 1-1-10

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” for the month(s) during which the individual establishes Medicaid eligibility. MMIS will generate the “Notice of Obligation for LTC Costs” and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

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

| | | |
|------------|-----------------------------|--|
| \$1,821.25 | 7-1-09 (no change for 2010) | |
| \$1,750.00 | 7-1-08 | |
- C. Maximum Monthly Maintenance Needs Allowance**

| | | |
|------------|------------------------------------|--|
| \$2,739.00 | <i>1-1-11 (no change for 2011)</i> | |
| \$2,739.00 | 1-1-10 | |
- D. Excess Shelter Standard**

| | | |
|----------|-----------------------------|--|
| \$546.38 | 7-1-09 (no change for 2010) | |
| \$525.00 | 7-1-08 | |
- E. Utility Standard Deduction (SNAP Stamps Program)**

| | | |
|-------|-----------------------------|----------------|
| \$303 | 1 - 3 household members | <i>10-1-10</i> |
| \$382 | 4 or more household members | <i>10-1-10</i> |
| \$302 | 1 - 3 household members | 10-1-09 |
| \$381 | 4 or more household members | 10-1-09 |

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
 $\frac{2}{400}$ ½ remainder
 + 75 first \$75 per month
 \$475 which is > \$190

His personal needs allowance is calculated as follows:

\$ 40.00 basic personal needs allowance
 +190.00 special earnings allowance
 + 17.50 guardianship fee (2% of \$875)
 \$247.50 personal needs allowance

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

Deduct the appropriate maintenance allowance for one person as follows:

1) For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, Day Support (DS) Waiver or PACE:

- January 1, 2011 through December 31, 2011: \$1,112 (no change for 2011).
- January 1, 2010 through December 31, 2010: \$1,112.

Contact a Medical Assistance Program Consultant for the SSI amount in effect for years prior to 2010.

2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person (\$2,022 in 2011).

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- the patient has a legally appointed guardian or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance For EDCD, DD, DS and ID/MR Waivers

[EXAMPLE #19 was deleted]

For EDCD, DD, DS and ID/MR Waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022 in 2011) per month.
- 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348 in 2011) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the ID/MR Waiver is employed 18 hours per week. He has gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

| | |
|------------|---------------------|
| \$ 928.80 | gross earned income |
| - 1,024.00 | 200% SSI maximum |
| \$ 0 | remainder |

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

| | |
|------------|--------------------------------|
| \$ 512.00 | maintenance allowance |
| + 928.80 | special earnings allowance |
| \$1,440.80 | personal maintenance allowance |

M1510 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|-------------------------------------|
| TN #95 | 3/1/11 | Table of Contents Pages 8, 11-15 |
| TN #94 | 9/1/10 | pages 2a, 8-8a |
| TN #93 | 1/1/10 | page 6 |
| Update (UP) #2 | 8/24/09 | page 11 |
| TN #91 | 5/15/09 | page 14 |

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M1510.000 MEDICAID ENTITLEMENT

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- 3. Spenddown Enrollees** Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.
- C. Ongoing Entitlement After Resources Are Reduced** When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).
- Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).
- When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

- A. Policy** When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.
- When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.
- B. Procedures**
- 1. Subsequent SSA/SSI Disability Decisions** The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application *as long as the disability onset date is prior to or no later than 90 days from the date of application.*
- 2. Use Original Application** The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is *no later than 90 days from the date of application.*
- 3. Entitlement** If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual

MN spenddown because of excess resources. The notice must specify the dollar amount of the appropriate MN resource limit.

2) If the QMB's resources are within the MN income limit, and income exceeds the MI limit, the notice must state that the applicant is not eligible for full-benefit Medicaid because of excess income, but that the applicant can become eligible by incurring medical or dental expenses that equal or exceed his excess income. The notice must specify the spenddown amount, the spenddown period begin and end dates, and include a copy of the Spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

There are instances when an applicant is not eligible for ongoing Medicaid coverage but is eligible for retroactive benefits, or when a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one "Notice of Action on Medicaid and FAMIS" (Form 032-03-008) is sent to the applicant covering both actions. The begin and end dates of Medicaid coverage and the reason(s) for ineligibility must be included on this notice.

4. Example #7 Limited Period of Entitlement

A Medicaid application was filed on December 30. The client inherited real property on January 30. The agency processed the application on February 5 and determined the client was eligible for Medicaid for the months of December and January, but was ineligible for additional coverage beginning February because the countable value of the inheritance caused excess resources. One notice is sent to the applicant stating that his Medicaid application was approved beginning December 1 and ending January 31, and that he was denied coverage after January 31 because of excess resources (real property).

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

Medicaid is a "last pay" program and cannot pay any claim for service until the service provider has filed a claim with the recipient's liable third parties such as health insurance companies or legally liable person. The procedures depend on the type of third party liability (TPL) the recipient has.

B. Private Health Insurance

Information on *an eligible individual's* private health insurance coverage must be obtained and recorded in the case record and in the MMIS. This must include the company name (code number for the TPL file), the policy number, and the begin date of coverage. *This information does NOT require verification.*

Health insurance policy or coverage changes must be updated in the eligibility record and *the MMIS* TPL file.

1. Verification Required - Policy or Coverage Termination

*Verification of the date the health insurance policy and/or a coverage type terminated is required. The verification of the termination date can be a written letter from, or verbal statement by, the insurance company that states the termination date. If verification is obtained, the worker is to **end-date** the TPL coverage in MMIS (note: do not delete the TPL from MMIS).*

Absent receipt of documentation showing that the TPL coverage has ended, it must be left open in MMIS and cannot be ended by the worker. If the worker is unable to obtain verification of the coverage termination date from the insurance company or the enrollee/authorized representative, the worker is to notify DMAS that the enrollee's TPL coverage was terminated, but verification cannot be obtained. The notification should be sent via e-mail to: tplunit@dmass.virginia.gov. If it is determined that TPL coverage no longer exists, the coverage will be closed in MMIS by DMAS staff.

2. HIPP

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

Changes to TPL coverage in MMIS for HIPP participants can only be made by the HIPP Unit at DMAS. Call the HIPP Unit at 1-800-432-5924 when changes to the TPL information in MMIS are needed.

C. Medicare

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare to provide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN, CNNMP or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);
- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Centers for Medicare and Medicaid Services(CMS) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before CMS will admit an individual to the buy-in list for Part B coverage, the individual must have established his eligibility for Medicare. His name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number on the MMIS and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a Social Security claim number or a Railroad Retirement claim number.

- a. SSA claim numbers consist of a nine-digit number followed by a letter, or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.
- b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.
- c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

**3. Procedures for
Obtaining
Claim Numbers**

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with his name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the MMIS eligibility file maintained by the Department of Medical Assistance Services.

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

Should the applicant be uncooperative (not wish to apply) or be deceased, the Social Security Office will contact the local social services department and ask that agency to file the Medicare application in his behalf. A local department of social services must also submit an application for Medicare on behalf of an individual who is unable or unwilling to apply. When the local department must file a Medicare application, the local Social Security office will advise the local department of the procedure to follow.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

| Classifications | Buy-in Begin Date |
|---|--------------------------------------|
| Category Needy Cash Assistance | 1st month of eligibility |
| ABD MI (includes dually-eligible) | 1st month of eligibility |
| Categorically Needy Non-money Payment and Medically Needy who are dually-eligible (countable income < 100% FPL and Medicare Part A) | 1st month of eligibility |
| Categorically Needy Non-money Payment and Medically Needy who are not dually-eligible (countable income > 100% FPL or no Medicare Part A) | 3 rd month of eligibility |

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

M1510.303 PATIENT PAY INFORMATION

- A. Policy** After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, the worker enters the information in MMIS. MMIS sends the "Notice of Obligation for Long-Term Care Costs" to the enrollee or the enrollee's authorized representative.
- B. Procedure** When patient pay increases, the MMIS "Notice of Obligation for Long-Term Care Costs" is sent in advance of the date the new amount is effective.

M1520 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|--|
| TN #95 | 3/1/11 | Pages 6a, 7, 21, 22 |
| TN #94 | 9/1/10 | Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed. |
| UP #4 | 7/1/10 | page 4 |
| TN #93 | 1/1/10 | pages 3, 4b, 5-6, 10, 15 pages 21, 22 |
| Update (UP) #2 | 8/24/09 | pages 1, 2, 13, 14, 17, 18 |
| Update (UP) #1 | 7/01/09 | page 3 |

Use cancel reason “042” when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child’s Medicaid coverage.

**5. FAMIS Plus
Child Turns Age
19**

When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If information in the case record indicates that the child is disabled or may be disabled, verify the child’s SSI benefits through SVES *or* SOLQ-I. If the child does not receive SSI, complete a referral to Disability Determination Services (DDS) following the procedures in M0310.112. The referral to DDS should be made at least 90 calendar days prior to the child’s 19th birthday.

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, the ABD Medicaid Renewal Form 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.
- 11. Qualified Individuals** *Coverage for individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility.*
- Renewals for all QIs are due by December 31 of each year. On or after November 1 of each year, send the [ABD Medicaid Renewal Form \(#032-03-0186\)](#) to all individuals currently enrolled in the QI covered group. Follow the ABD Medicaid renewal procedure to request verifications and complete the evaluation.*
- a. Renewal form returned BEFORE December 31st**
- If the individual remains eligible for QI coverage, do not act on the renewal (i.e. change the renewal date) in MMIS prior to December 31. On or after January 1 of the following year, reinstate the QI coverage in MMIS, effective January 1. Change the renewal date in MMIS to December 31. Send a [Notice of Action on Medicaid and FAMIS \(form #032-03-0008\)](#) indicating that the individual's coverage continues and the date of the next renewal.*
- b. Renewal form returned AFTER December 31st**
- If the renewal form is not returned by December 31st the individual must submit a new application for Medicaid. The MMIS-generated cancellation notice will serve as the 10-day advance notice for cancellation of the individual's QI coverage.*
- 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.

For family members who are not eligible for Medicaid or FAMIS-FAMIS MOMS, **send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month.

If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

M1520.600 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

C. DBHDS Facilities

The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from Department of Behavioral Health and Developmental Services (DBHDS) facilities are in subchapter M1550. F&C cases are not transferred to the DBHDS facilities.

D. Cases From DMAS FAMIS Plus Unit FIPS 976

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).

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.

Do not review eligibility for cases transferred from the DMAS FAMIS Plus Unit for eligibility until (1) a change is reported that potentially impacts the individual's non-financial or financial Medicaid eligibility or (2) the annual renewal is due.

When converting the case into ADAPT, use the gross monthly income for each individual in the FAMIS Plus assistance unit who has income to ensure that the income determination made by the FAMIS Plus Unit is captured. On the ADAPT income screen, use the "Monthly" code for frequency even if the income is received more or less frequently. Complete instructions for entering a case transferred from the FAMIS Plus Unit into ADAPT are available at: <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.

LDSS will not be held responsible for errors found if the case is pulled for a program integrity review or audit as long as (1) no partial review or annual renewal was completed since the case transfer and (2) the annual renewal is not overdue.

- E. Cases From Outstationed Workers**
- Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) or the workers at Medical College of Virginia (MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS **to** outstationed workers.
- 1. Confirm Receipt**
The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.
 - 2. Review Eligibility**
LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.
 - 3. Corrective Action**
If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.
- F. Local Agency to Local Agency**
- When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:
- 1. Sending Locality Responsibilities**
 - a. Case Renewal Cannot Be Overdue**
The sending locality must make certain the case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case.

If the annual renewal is due in the month the LDSS plans to transfer the case or the following month, the renewal must be completed before transferring the case.

Exception: When the Medicaid case is in ADAPT and SNAP is active in the ADAPT case, the SNAP case transfer rules override the Medicaid policy that the Medicaid renewal cannot be overdue. The ADAPT case must be transferred immediately to the new locality, even if the Medicaid renewal is overdue, due in the transfer month or due in the following month to comply with the SNAP case transfer rule.
 - b. When Renewal Must Be Completed Before Transferring**
If the sending LDSS must complete the renewal before transferring the case, the Sending LDSS must keep the case record to complete the renewal.

The sending locality must update the enrollees' MMIS records as follows to assure managed care continuity:

M18 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|--------------------------------|
| TN #95 | 3/1/11 | page 9 |
| TN #94 | 9/1/10 | page 12 |
| TN #93 | 1/1/10 | pages 4, 5 |
| TN #91 | 5/15/09 | page 2 pages 5, 6 page 8 |

For recipients who have been placed in the Client Medicaid Management Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Recipients who have problems with bills or services from providers of care should be referred as follows:

Fee-for-Service Medicaid Recipients

Fee-for-service Medicaid recipients should be referred to the DMAS Recipient Helpline at 804-786-6145. Recipients who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331.

Recipients Enrolled in Managed Care

Recipients enrolled in managed care should be referred to the Managed Care Helpline at 800-643-2273. Medallion II enrollees may also contact their MCO directly. MEDALLION enrollees who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331. Medallion II enrollees who need assistance with transportation must contact their MCO directly.

B. Copayments

a. Medicaid Enrollees without Medicare

Most Medicaid covered services have a "copayment," which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from \$1.00 to \$3.00 for most services. There is a \$100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the recipient at the time the service is provided.

b. Medicare Beneficiaries

Individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB) are responsible for Medicaid copayments only. Medicaid covers the remainder of the Medicare copayment for these individuals. However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

M21 Changes

| Changed With | Effective Date | Pages Changed |
|---------------------|-----------------------|---|
| TN #95 | 3/1/11 | Table of Contents pages 5, 6, 14, 15 page 16 was added. Appendix 1 |
| TN #94 | 9/1/10 | page3 Appendix 3, pages 1 and 2 |
| UP #3 | 3/1/10 | pages 2-5 |
| TN #93 | 1/1/10 | page 2-4, 8 |
| Update (UP) #2 | 8/24/09 | page 4 |

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- *Medicare*
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

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

2. Family Member

When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, or whether the discontinuance of health insurance affects the child's eligibility, family member means:

- parent(s) with whom the child is living, and
- a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

3. Health Benefit Plan

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- "any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

Health benefit plan does not mean:

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

4. Insured

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

5. Uninsured

means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy

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

- have creditable health insurance coverage;

- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) *or Medicare*;
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 2 to this chapter], or

without good cause (see item E. below), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

D. Health Insurance Coverage Discontinued

If the child's insurance coverage was discontinued by a parent or other individual who does NOT live with the child, the discontinuance of the insurance does NOT affect the child's eligibility for FAMIS.

A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated by a family member, as defined in M2120.200 B.3, above, without good cause within four months prior to the month for which eligibility is being established, unless the child was pregnant at the time of application.

Example: A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within four months of November. He may be eligible in April because his insurance was terminated more than four months prior to April.

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

E. Good Cause for Dropping Health Insurance

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

1. **Employment Stopped** The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
2. **Employer Stopped Contributing** The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

When an application is approved for FAMIS or FAMIS MOMS, the FAMIS CPU initiates the managed care assignment and provides ongoing case maintenance. When an application is not FAMIS Plus-likely and is not eligible for FAMIS or FAMIS MOMS, the CPU sends the denial or cancellation notice to the applicant. When an application is determined as FAMIS Plus-likely, the application is sent over to the DMAS FAMIS Plus Unit for a Medicaid eligibility determination.

I. DMAS FAMIS Plus Unit Responsibilities and Procedures

FAMIS Plus-likely applications referred to the DMAS FAMIS Plus Unit from the FAMIS CPU are recorded on a daily log. All referred applications are screened for FAMIS Plus eligibility by the DMAS FAMIS Plus Unit. FAMIS Plus-likely applications connected to active cases in ADAPT or MMIS are transferred to LDSS for processing, and notice of the transfer is sent to the family. The application, the verifications, and a copy of the notice are placed in a sealed envelope and transferred to the LDSS via the courier no later than the next business day.

The DMAS FAMIS Plus Unit processes FAMIS Plus-likely applications that have been pending 25 days or more, and transfers enrolled FAMIS Plus cases to the LDSS. If the unit's screening determines that the application is not FAMIS Plus-likely, then a FAMIS eligibility determination is completed and the case is returned to the FAMIS CPU in an approved or denied status.

FAMIS redeterminations and renewals are also screened for FAMIS Plus eligibility and, if FAMIS Plus-likely, are referred to the DMAS FAMIS Plus Unit. If the FAMIS Plus-likely FAMIS redetermination or renewal is connected to an active case in ADAPT or MMIS, the case is transferred to the LDSS for the FAMIS Plus determination. If the FAMIS Plus-likely FAMIS redetermination/renewal is not connected to an active case, the DMAS FAMIS Plus Unit completes the FAMIS Plus determination and transfers the approved ongoing case to the LDSS.

J. FAMIS Administrative Renewals

The FAMIS CPU uses an administrative renewal procedure for all FAMIS redeterminations of eligibility. The CPU sends the FAMIS family a pre-printed renewal form containing the information, including gross income, contained in the CHAMPS (FAMIS) eligibility system. Families are asked to review the form and, if there have been no changes in the family situation or income, attest to the correctness of the information and send the form back to the CPU for processing.

If the returned form indicates no changes, eligibility staff at the CPU administratively renews the case for another year without the need for receipt of any verifications. If the family returns the form, but indicates a change in income, staff at the CPU first tries to electronically verify the income through available sources. If online verification is not available, a "deficiency" letter is sent to the family requesting proof of income. Cases that are administratively renewed are subject to random audits to ensure that correct income information was used in determining ongoing eligibility for FAMIS.

It is possible that the family may inadvertently send the pre-printed FAMIS renewal form to the LDSS. If that occurs, send the form to the FAMIS CPU for case processing.

K. DMAS Contacts at the CPU

The DMAS FAMIS Plus Unit eligibility workers are designated as the liaisons between the LDSS workers and the FAMIS CPU staff. The FAMIS Plus Unit workers are assigned to specific geographic areas. These assignments were made to improve communication and facilitate resolution to problems involving cases that have been transferred between the CPU and LDSS. The DMAS FAMIS Plus workers are assigned to five geographic areas of the state. The geographic areas correspond to the LDSS regions. The list of the DMAS FAMIS Plus workers and the areas they serve is available on the DSS intranet in the Benefit Programs, Medicaid Eligibility, ME Contacts folder at: <http://localagency.dss.virginia.gov/divisions/bp/me/contacts.cgi>.

The DMAS FAMIS Plus workers will:

- act as contact persons for cases transferred to the CPU and the LDSS, answer non-policy related questions regarding transferring or closing cases, and
- change worker number V0000 to M0000 when necessary.

The DMAS FAMIS Plus workers will not provide policy clarification and will not handle client complaints. Please continue to contact your supervisor or Medical Assistance Program Consultant for assistance with policy clarifications, computer system problems, and client complaints.

Please note that the DMAS FAMIS Plus workers' telephone numbers are for the LDSS workers only and **are not to be given to clients**. The CPU has a separate toll-free FAMIS helpline number (1-866-87FAMIS or 1-866-873-2647) designated for client use. This toll-free FAMIS telephone number is **not** for use by LDSS workers.

L. FAMIS Select

Under the FAMIS program, a family, whose child(ren) are determined eligible for FAMIS and who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

**M. 12-Month
Continuous
Coverage**

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

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

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

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

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

| FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/20/11 | | | | |
|---|---------------------------|---------------|---------------------------|---------------|
| # of Persons in FAMIS Assistance Unit | FAMIS 150% FPL | | FAMIS 200% FPL | |
| | Annual Limit | Monthly Limit | Annual Limit | Monthly Limit |
| 1 | \$16,335 | \$1,362 | \$21,780 | \$1,815 |
| 2 | 22,065 | 1,839 | 29,420 | 2,452 |
| 3 | 27,795 | 2,317 | 37,060 | 3,089 |
| 4 | 33,525 | 2,794 | 44,700 | 3,725 |
| 5 | 39,255 | 3,272 | 52,340 | 4,362 |
| 6 | 44,985 | 3,749 | 59,980 | 4,999 |
| 7 | 50,715 | 4,227 | 67,620 | 5,635 |
| 8 | 56,445 | 4,704 | 75,260 | 6,272 |
| Each additional, add | 5,730 | 478 | 7,640 | 637 |

M22 Changes

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| TN #95 | 3/1/11 | pages 4-6 Appendix 1 |
| UP #4 | 7/1/10 | page 10 |
| TN #94 | 9/1/10 | page 3 |
| UP #3 | 3/01/10 | page 2 |
| TN #93 | 1/1/10 | pages 2-10 |
| UP #2 | 8/24/09 | page 3 |
| Update (UP) #1 | 7/1/09 | pages 1, 2, 7 Appendix 1, page 1 |

**D. FAMIS MOMS
Covered Group
Requirements**

- 1. Verification of Pregnancy** Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, public health nurse or similar medical practitioner.

Documentation of how the pregnancy was verified must be included in the case record.
- 2. Must be Uninsured** The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.
- 3. IMD Prohibition** The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).
- 4. State Employee Health Benefits Prohibition** A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage.

See Appendix 2 to Chapter M21 for a list of state government agencies.

M2220.200 HEALTH INSURANCE COVERAGE

A. Introduction The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

1. Creditable Coverage For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:

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

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

- 2. Employer-Sponsored Dependent Health Insurance** Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.
- 3. Family Member** ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, “family member” means the pregnant woman’s spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. “Family member” includes the pregnant woman’s stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee’s unmarried **dependent** child or stepchild under age 23 years.
- 4. Health Benefit Plan** “Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
- any accident and health insurance policy or certificate,
 - health services plan contract,
 - health maintenance organization subscriber contract,
 - plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.
- Health benefit plan does NOT mean:
- Medicaid or State/Local Hospitalization;
 - accident only;
 - credit or disability insurance;
 - long-term care insurance;
 - dental only or vision only insurance;
 - specified disease insurance;
 - hospital confinement indemnity coverage;
 - limited benefit health coverage;
 - coverage issued as a supplement to liability insurance;
 - insurance arising out of workers’ compensation or similar law;
 - automobile medical payment insurance; or
 - insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
- 5. Insured** means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.
- 6. Uninsured** means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

- 1. Must be Uninsured**

A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot**:

 - have creditable health insurance coverage;
 - have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or *Medicare*;
 - be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to chapter M21].

- 2. Prior Insurance**

Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

- A. Policy** There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

- 1. FAMIS MOMS Assistance Unit**

The FAMIS MOMS assistance unit policy is the same as the Medicaid pregnant woman assistance unit policy. Use subchapter M0520, F&C Family/Budget Unit, to determine the pregnant woman's family unit for her financial eligibility determination. If ineligible in the family unit, determine her eligibility in the budget unit (if appropriate). The unborn child(ren) is counted as part of the family unit.

- 2. Asset Transfer**

Asset transfer rules do not apply to FAMIS MOMS.

- 3. Resources**

Resources are not evaluated for FAMIS MOMS.

- 4. Income**
 - a. Countable Income**

The source and amount of all income other than Workforce Investment Act, Supplemental Security Income (SSI) and student income, must be verified and counted. FAMIS MOMS uses the same income types and methods for estimating income as in Medicaid Families & Children (F&C) policy (see chapter M07).

| FAMIS MOMS INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/20/11 | | |
|--|---|---------------|
| # of Persons in FAMIS MOMS Assistance Unit | FAMIS MOMS 200% FPL | |
| | Annual Limit | Monthly Limit |
| 2 | \$29,420 | \$2,452 |
| 3 | 37,060 | 3,089 |
| 4 | 44,700 | 3,725 |
| 5 | 52,340 | 4,362 |
| 6 | 59,980 | 4,999 |
| 7 | 67,620 | 5,635 |
| 8 | 75,260 | 6,272 |
| Each additional, add | 7,640 | 637 |