April 1, 2012

MEDICAID MANUAL – VOLUME XIII

POLICY UPDATE #6

The following acronyms are used in this update:

- ABD – Aged, Blind or Disabled
- CBC – Community-based Care
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Level
- LTC – Long-term Care
- MI – Medically Indigent
- MSP – Medicare Savings Programs
- QDWI – Qualified Disabled Working Individuals
- QI – Qualified Individuals
- QMB – Qualified Medicare Beneficiaries
- SLMB – Special Low Income Medicare Beneficiaries
- SPARK – Services, Programs, Answers, Resources, Knowledge
- SSI – Supplemental Security Income
- UP - Update
- VDSS – Virginia Department of Social Services

Medicaid Policy Update #6 contains the SSI-based income limits and standards, as well as the LTC home equity limit, spousal standards and maintenance standards, for 2012. UP #6 also contains the Medicare premium amounts and MSP resource limits for 2012. These figures were posted in Broadcasts 7243 and 7265 and became effective January 1, 2012.

UP #6 also contains revised policy regarding medical expense deductions from patient pay. Effective January 1, 2012, individuals receiving Medicaid CBC services are no longer responsible for prescription co-pays for medications covered under their Medicare Part D prescription drug plans. The policy on allowing the guardianship payment allowance was also clarified. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

The Medicaid, FAMIS and FAMIS MOMS income limits that are based on a percentage of the FPL are also included in UP #6. These income limits were announced in Broadcast 7328 and became effective January 26, 2012 for individuals who do not receive Social Security benefits and all MEDICAID WORKS and QDWI enrollees. The income limits became effective March 1, 2012 for Social Security beneficiaries in the Individuals with Income ABD $\leq$ 80% FPL, QMB, SLMB, and QI covered groups. The revised income limits were posted in Broadcast 7328

UP #6 is available on SPARK and the VDSS public web site. The changes to the manual are as follows:

Pages Changed	Significant Changes
Subchapter M0320 pages 11, 12, 46a	On pages 11 and 12, updated the Social Security and Medicare information for 2012. On page 46a, updated the resource limit for MEDICAID WORKS.
Subchapter M0530 Appendix 1, page 1	On Appendix 1, page 1, updated the deeming standards for 2012.
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 2012.
Subchapter M0810 pages 1, 2	On pages 1 and 2, updated the SSI-based and ABD MI income limits for 2012.
Subchapter S0820 pages 30, 31	On pages 30 and 31, updated the blind or disabled student child earned income exclusion amount for 2012.
Subchapter S1110 page 2	On page 2, updated the resource limits for the QMB, SLMB and QI covered groups.
Subchapter M1460 pages 3, 35	On page 2, updated the home equity limit for 2012. On paged 35, updated the blind or disabled student child earned income exclusion amount for 2012.
Subchapter M1470 pages 4, 9, 19, 20, 24, 26	On pages 4 and 19, clarified that no deduction is allowed from an individual's patient pay if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. On pages 9 and 24, updated the Medicare Part D benchmark premium amount for 2012. On page 19, also updated the personal allowance amounts for 2012. On page 20, updated the special earnings allowance amounts for 2012. On page 26, revised the policy for giving a patient pay allowance for Medicare Part D prescription copayments for individuals receiving CBC.
Subchapter M1480 pages 7, 18c, 66, 68, 69, 70	On page 7, updated the home equity limit for 2012. On page 18c, updated the spousal resource standards for 2012. On page 66, updated the maximum monthly maintenance needs allowance amount for 2012. On pages 68 and 69, added the notes on deducting guardianship fees from patient pay that are already in M1470. On page 69, also updated the personal maintenance allowance amounts for 2012. On page 70, updated the special earnings allowance amounts for 2012.
Chapter M21 Appendix 1	In Appendix 1, updated the FAMIS income limits for 2012.
Chapter M22 Appendix 1	In Appendix 1, updated the FAMIS MOMS income limits for 2012.

Questions about information contained in Medicaid Policy Update #6 should be directed to Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.

M0320 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	pages 11, 12, 46a
TN #96	10/1/11	Table of Contents pages 46f-50b page 50c deleted
TN #95	3/1/10	pages 11, 12, 42c, 42d, 50, 53, 69 pages 70, 71 page 72 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. $\frac{\textit{Current Title II Benefit}}{\textit{1.036 (1/12 Increase)}} = \textit{Benefit Before 1/12 COLA}$

b. Current Title II Benefit = Benefit Before
1.058 (1/09 Increase) 1/09 COLA

c. Benefit before 1/09 COLA = Benefit Before
1.023 (1/08 Increase) 1/08 COLA

d. Benefit Before1/08 COLA = Benefit Before
1.033 (1/07 Increase) 1/07 COLA

e. Benefit Before 1/07 COLA = Benefit Before
1.041 (1/06 Increase) 1/06 COLA

Contact a Medical Assistance Program Consultant for amounts for years prior to 200*6*.

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-12 $99.90
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

*****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 *was* $96.40 for 2010 and 2011. The Medicare Part B premium for individuals enrolled in Medicare between January 1, 2010 and December 31, 2010 *was* $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:

1-1-12 $451.00
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

Contact a Medical Assistance Program Consultant for amounts for years prior to *2006*.

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.

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

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

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

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for *2012* is *$34,272*.

M0530 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	page 14
TN #95	3/1/11	page 1 Appendix 1, page 1
TN #93	1/1/10	pages 11, 19 Appendix 1, page 1

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

2012: $1,048 - $698 = $350
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 = *$698 for 2012;* $674 for 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 = *$1,048 for 2012;* $1,011 for 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

2012: $1,048 - $698 = $350
2010 and 2011: $1,011 - $674 = $337

M0710 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
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 *1-26-12 ALL LOCALITIES**			
# of persons in Family/Budget Unit	**100% FPL Monthly Limit**	**133% FPL Monthly Limit**	**200% FPL Monthly Limit***
1	*$931*	*$1,239*	*$1,862*
2	*1,261*	*1,677*	*2,522*
3	*1,591*	*2,116*	*3,182*
4	*1,921*	*2,555*	*3,842*
5	*2,251*	*2,994*	*4,502*
6	*2,581*	*3,433*	*5,162*
7	*2,911*	*3,872*	*5,822*
8	*3,241*	*4,311*	*6,482*
Each additional person add	*330*	*439*	*660*

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 to19 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 *200%* FPL (effective **10-01-2011***)*.

MEDICALLY INDIGENT PREGNANT WOMAN INCOME LIMITS 133% FPL EFFECTIVE *1-26-12* ALL LOCALITIES	
# of persons in Family/Budget Unit	**133% FPL Monthly Limit**
2	*1,677*
3	*2,116*
4	*2,555*
5	*2,994*
6	*3,433*
7	*3,872*
8	*4,311*
Each additional person add	*439*

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 *1-26-12* ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	**185% FPL Monthly Limit**
1	*$1,723*
2	*2,333*
3	*2,944*
4	*3,554*
5	*4,165*
6	*4,775*
7	*5,386*
8	*5,996*
Each additional person add	*611*

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	4/1/12	pages 1, 2
UP #5	7/1/11	page 2
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	*2012* Monthly Amount	2011 Monthly Amount
1	*$698*	$674
2	*1,048*	1,011
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	*2012* Monthly Amount	2011 Monthly Amount
1	*$465.33*	$449.33
2	*698.67*	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 1	*2012* Monthly Amount *$2,094*	2011 Monthly Amount $2,022

4. Medically Needy (Effective July 1, 2011)

a. Group I		
Family Unit Size 1 2	Semi-annual $1,711.70 2,179.46	Monthly $285.28 363.24
b. Group II		
Family Unit Size 1 2	Semi-annual $1,975.04 2,432.27	Monthly $329.17 405.37
c. Group III		
Family Unit Size 1 2	Semi-annual $2,567.56 3,095.78	Monthly $427.92 515.96

5. ABD Medically Indigent

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; all MEDICAID WORKS, effective *1/26/12*

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income, effective 3/1/12

ABD 80% FPL 1 2	Annual *$8,936* *12,104*	Monthly *$745* *1,009*
QMB 100% FPL 1 2	Annual *$11,170* *15,130*	*Monthly* *$931* *1,261*
SLMB 120% of FPL 1 2	Annual *$13,404* *18,156*	Monthly *$1,117* *1,513*
QI 135% FPL 1 2	Annual *$15,080* *20,426*	Monthly *$1,257* *1,703*
QDWI and MEDICAID WORKS 200% of FPL 1 2	Annual *$22,340* *30,260*	Monthly *$1,862* *2,522*

S0820 Changes

Changed With	Effective Date	Pages Changed
Update (UP) #6	4/1/12	pages 30, 31
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

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 *2012, up to $1,700 per month, but not more than $6,840 in a calendar year, of the earned income of a blind or disabled student child.*

For 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 year 2012	*$1,700*	*$6,840*
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.

S1110 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	page 2
TN #96	10/1/11	page 2
TN #95	3/1/11	page 2
Update (UP) #3	3/1/10	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 ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** ***2012*** *$6,940* **2011** $6,680	**Calendar Year** ***2012*** *$10,410* **2011** $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.

M1460 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	pages 3, 35
TN #96	10/1/11	pages 3, 20, 21
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.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

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
- *Effective January 1, 2012: $525,000.*

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. For *2012, up to $1,700 per month, but not more than $6,840 in a calendar year, of the earned income of a blind or disabled student child.*

For 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

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	pages 3, 4, 7-9, 19, 22-24, 43
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

2. Dependent Child Allowance See section M1470.220 "Dependent Child Allowance."

3. Noncovered Medical Expenses See section M1470.230 "Facility - Noncovered Medical Expenses."

4. Home Maintenance Deduction See section M1470.240 "Facility - Home Maintenance Deduction."

C. Appeal Rights The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

1. Basic Personal Allowance Deduct $40 per individual, effective July 1, 2007. The basic personal allowance for prior months is $30.

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 if the patient's guardian *receives a payment for providing guardianship services* from a public agency or organization that receives funding for guardianship services.

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

3. Special Earnings Allowance Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

6. **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 *2012* is *$30.95*.

7. 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, 2012 through December 31, *2012*: *$1,151*
- January 1, 2011 through December 31, 2011: $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 if the patient's guardian *receives a payment for providing guardianship services* from a public agency or organization that receives funding for guardianship services.

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 *($2,094* in *2012*) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,396* in *2012*) 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.

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 *2012* is *$30.95.*

5. **LTC Insurance**

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC 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 waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider 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. Noncovered 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.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

1. Zero Patient Pay Procedures

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

Notify the patient or the patient's representative using the Notice of Action.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

2) routine dental care, necessary dentures and denture repair for recipients 21 years of age and older;

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

8) copayments for prescription drugs obtained under Medicare Part D.

e. Medicare Part D copays

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to CBC

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP *were* responsible for the payment of co-pays *for prescriptions filled prior to January 1, 2012. Effective January 1, 2012, individuals receiving Medicaid CBC services are not responsible for co-pays prescriptions covered under their Medicare Part D PDP*. *CBC recipients are* not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, 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.

M1480 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	pages 7, 14, 66, 71
UP #5	7/1/11	page 66
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, 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.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

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
- *Effective January 1, 2012: $525,000.*

2. Reverse Mortgages Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

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	*$22, 728*	*1-1-12*
	$21,912	1-1-11
C. Maximum Spousal Resource Standard	*$113, 640*	*1-1-12*
	$109,560	1-1-11

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	$1,838.75	7-1-11		
	$1,821.25	7-1-10		
C. Maximum Monthly Maintenance Needs Allowance	*$2,841.00*	*1-1-12*		
	$2,739.00	1-1-11		
D. Excess Shelter Standard	$551.63	7-1-11		
	$546.38	7-1-10		
E. Utility Standard Deduction (SNAP)	$274	1 - 3 household members	10-1-11	
	$345	4 or more household members	10-1-11	
	$303	1 - 3 household members	10-1-10	
	$382	4 or more household members	10-1-10	

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).

- personal needs or maintenance allowance,
- community spouse monthly income allowance,
- family member's income allowance,
- non-covered medical expenses,
- home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver or PACE. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care

a. Basic Allowance

Deduct the $40 basic allowance, effective July 1, 2007. For prior months, the personal needs allowance is $30.

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 income) for guardianship fees, IF:

* the patient has a legally appointed guardian and/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.

NOTES: *No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services*. The guardianship filing fees CANNOT be deducted from the individual's income.

. Special Earnings Allowance

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

* the first $75 of gross monthly earnings, PLUS
  * ½ the remaining gross earnings,
  * up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of $875 per month. His special earnings allowance is calculated first:

$875 gross earned income
- 75 first $75 per month
800 remainder
÷ 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, 2012 through December 31, 2012: $1,151*
- January 1, 2011 through December 31, 2011: $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 (*$2,094 for 2012*).

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.

NOTES: *No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services*. 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 (*$2,094 for 2012*) per month.

2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,396 for 2012*) 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

M21 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 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

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/26/12*

# of Persons in FAMIS Assistance Unit	**FAMIS 150% FPL**		**FAMIS 200% FPL**	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	*$16,755*	*$1,397*	*$22,340*	*$1,862*
2	*22,695*	*1,892*	*30,260*	*2,522*
3	*28,635*	*2,387*	*38,180*	*3,182*
4	*34,575*	*2,882*	*46,100*	*3,842*
5	*40,515*	*3,377*	*54,020*	*4,502*
6	*46,455*	*3,872*	*61,940*	*5,162*
7	*52,395*	*4,367*	*69,860*	*5,822*
8	*58,335*	*4,862*	*77,780*	*6,482*
Each additional, add	*5,940*	*495*	*7,920*	*660*

M22 Changes

Changed With	Effective Date	Pages Changed
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 3a
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

FAMIS MOMS
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/26/12*

# of Persons in FAMIS MOMS Assistance Unit	**FAMIS MOMS 200% FPL**	
	Annual Limit	Monthly Limit
2	*$30,260*	*$2,522*
3	*38,180*	*3,182*
4	*46,100*	*3,842*
5	*54,020*	*4,502*
6	*61,940*	*5,162*
7	*69,860*	*5,822*
8	*77,780*	*6,482*
Each additional, add	*7,920*	*660*