



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

May 27, 2004

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #77

The following acronyms are used in this transmittal:

- ABD – Aged, Blind, and Disabled
- AG – Auxiliary Grant
- CBC – Community-Based Care
- CS – Community Spouse
- DDS – Disability Determination Services
- DSS – Department of Social Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FPS – Family Planning Services
- GED – General Educational Development
- IS – Institutionalized Spouse
- LIFC – Low Income Families with Children
- LTC – Long-term Care
- MFU – Medicaid Family Unit
- MN – Medically Needy
- QDWI – Qualified Disabled Working Individuals
- TANF – Temporary Assistance for Needy Families
- VA – Veteran's Administration

This transmittal contains the new LIFC and MN income limits and LTC maintenance standards and allowances. The new income limits and maintenance standards are effective July 1, 2004.

This transmittal also contains changes to the definitions of a caretaker-relative and dependent child. The relationship as declared on the application/redetermination form is used to determine the caretaker-relative's relationship to the child and no verification of the relationship is required. The requirement that the child be deprived has been removed from the definition of a dependent child. A determination of deprivation is no longer made for applicants who meet the LIFC covered group.

Additional policy changes include the elimination of in-kind income as countable income for the F&C covered groups. In-kind contributions of food and clothing are no longer countable as unearned income.

As a result of legislation passed during the 2004 session of the General Assembly, there is a policy change in this transmittal that is currently limited to the Roanoke City DSS. Medicaid applications for patients in the Veteran's Care Center located in Roanoke may be filed, processed and maintained at the Roanoke City DSS.

Clarifications to policy in this transmittal include: Qualified Alien status for certain Cuban/Haitian Entrants for Medicaid and FAMIS; application for other benefits for non-applicant parents and spouses; redetermination requirements for FPS; inclusion in the F&C MFU for members who are temporarily away from home; counting interest as income for F&C covered groups; the process for rebutting the value of an automobile for the ABD covered groups; and life estates as non-countable resources for the ABD covered groups. In addition, the contact information for Civil Service has been updated.

Clarifications to LTC Medicaid policy include: post-eligibility transfers of assets by the CS; the treatment of VA payments for patient pay; and the exemption of copayments for CBC recipients.

All policy changes, clarifications and updates contained in this transmittal are effective for all eligibility determinations completed on or after July 1, 2004.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0120 pages 9-12	Subchapter M0120 pages 9-12	On page 9, clarified that a separate Medicaid application is not required with an AG application. On pages 10 and 12, clarified that applications for patients in the Veteran's Care Center in Roanoke may be made, processed and maintained at the Roanoke City DSS. Page 11 is a reprint.
Subchapter M0220 Appendix 3, page 1	Subchapter M0220 Appendix 3, page 1	In Appendix 3, clarified that Cuban and Haitian Entrants admitted as defined in section 501(e) of the Refugee Education Assistance Act of 1980, including those under section 212(d)(5), are Qualified Aliens.
Subchapter M0270 pages 1-3	Subchapter M0270 pages 1-3	On page 1, clarified that non-applicant parents or spouses are not required to apply for other benefits on their own behalf. Page 2 is a runover page. On page 3, updated the reference to DDS.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0310 pages 7-22	Subchapter M0310 pages 7-14 pages 21, 22	Page 7 is a reprint. On page 8-9, revised the requirements for verification of relationship and presence in the home in the definition of a caretaker-relative. Pages 10 and 11 are runover pages. On pages 12-14, clarified that a full-time student under the age of 19 may be enrolled in a GED program and removed the deprivation requirement from the definition of a dependent child. Pages 15-20 have been intentionally removed. Pages 21 and 22 are runover pages.
Subchapter M0320 pages 49, 50	Subchapter M0320 pages 49, 50	On page 49 and 50, clarified that enrollment in FPS is done without a redetermination unless the woman requests one. Women who have been determined eligible for full benefits under Medicaid are not eligible for FPS.
Subchapter M0520 pages 1, 2	Subchapter M0520 pages 1, 2	On page 1, clarified that a parent or non-emancipated child under age 21 is included in the MFU when temporarily away from the home. Page 2 is a reprint.
Chapter M07 Table of Contents, pages i, ii	Chapter M07 Table of Contents, pages i, ii	Deleted M0710, Appendix 4 from the Table of Contents, page i. Page ii is a reprint.
Subchapter M0710 Table of Contents Appendices 1, 3, 4 and 5	Subchapter M0710 Table of Contents Appendices 1, 3, 4 and 5	Deleted Appendix 4 from the Table of Contents. In Appendices 1 and 3, revised the F&C and 185% Standards of Need income limits.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0720 Appendix 1	Subchapter M0720 Appendix 1	Appendix 4 is intentionally blank. In Appendix 5, revised the F&C MN income limits.
Subchapter M0730 Table of Contents pages 9-12	Subchapter M0730 Table of Contents pages 9-12	In Appendix 1, deleted the reference to the TANF covered group.
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	Deleted Contributions In Kind from the Table of Contents. On page 9, clarified that interest income is only counted when earned on a countable resource. On page 10, revised the instructions for obtaining the standard food allowance for boarders. Page 11 is a reprint. On page 12, deleted the policy on contributions in kind.
Subchapter M0830 pages 27, 28	Subchapter M0830 pages 27, 28	Page 1 is a reprint. On page 2, revised the ABD MN income limits.
Subchapter M1130 pages 17, 18	Subchapter M1130 pages 17, 18	On page 27, updated the contact information for the Office of Personnel Management. Page 28 is a reprint.
Subchapter M1140 pages 11, 12	Subchapter M1140 pages 11, 12	On page 17, clarified the policy for rebutting the value of an automobile for the ABD covered groups. Page 18 is a reprint.
		On pages 11 and 12, clarified that life rights to real property are not a countable resource except for the QDWI covered group. On page 11, also deleted the reference to “life

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1450 pages 7-10 pages 15, 16	Subchapter M1450 pages 7-10 pages 15, 16	<p>estates with powers” because the regulation makes no distinction between “with” or “without powers.”</p> <p>Page 7 is a reprint. On pages 8 and 16, clarified that once eligibility as an IS is established, transfers of resources owned by the CS do not affect the IS’s continued eligibility for Medicaid payment of LTC services. On page 9, deleted the requirement to evaluate the CS’s assets after the IS’s eligibility is established. These clarifications pertain to asset transfers on or after August 11, 1993. Pages 10 and 15 are runover pages.</p>
Subchapter M1470 pages 1, 2	Subchapter M1470 pages 1, 2	<p>Page 1 is a reprint. On page 2, clarified that VA pension and Aid & Attendance payments are not counted when determining patient pay when the veteran has a spouse or dependent child or the deceased veteran’s surviving spouse has a dependent child.</p>
Subchapter M1480 pages 41, 42 pages 65, 66	Subchapter M1480 pages 41, 42 pages 65, 66	<p>On page 41, deleted the requirement to evaluate the CS’s resources at the end of the protected period and at redetermination because post-eligibility transfers of resources owned by the CS do not affect the IS’s continued eligibility for Medicaid payment of LTC services. Pages 42 and 65 are reprints. On page 66, updated</p>

 Remove and Destroy Pages

Insert Attached Pages

 Significant Changes

Subchapter M1800
pages 5, 6
pages 9, 10
Appendix 1

Subchapter M1800
pages 5, 6
pages 9, 10
Appendix 1

the Monthly Maintenance Needs Standard and the Excess Shelter Standard used for patient pay allowances.

On pages 5 and 6, revised the process for exempting a foster care/adoption assistance child from managed care. Page 9 is a reprint. On page 10, clarified that recipients of CBC are exempt from copayments. Appendix 1, The Foster Care Child Exemption from Medicaid Managed Care Programs form, is revised.

Chapter M21
Appendix 7, pages 1, 2

Chapter M21
Appendix 7, pages 1, 2

In Appendix 7, clarified that Cuban and Haitian Entrants admitted as defined in section 501(e) of the Refugee Education Assistance Act of 1980, including those under section 212(d)(5), are Qualified Aliens for the FAMIS program.

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



Duke Storen, Director
Division of Benefit Programs

Attachments

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

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

C. Other Medicaid Applications

1. Auxiliary Grant (AG)

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

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

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

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

D. Recipient Changes Assistance Unit

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

M0120.400 Place of Application

A. Principle

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

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

B. Children in State and Local Custody

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

1. Foster Care

a. Title IV-E Foster Care

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

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

b. State/Local Foster Care

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

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

2. Adoption Assistance

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

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

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

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

C. Institutionalized Individual (Not Incarcerated)

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

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

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

D. Individuals in DMHMRSAS Facilities

1. Patient in a DMH-MRSAS Facility

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

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

2. Patient Pending Discharge

a. General Policy

For DMHMRSAS facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the DMHMRSAS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,
- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

If the patient is found eligible, he is not enrolled in the Medicaid program until he has been discharged from the institution.

b. Pending Discharge to a Facility

If a patient who was not Medicaid eligible in the DMHMRSAS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

c. Pending Discharge to the Community

If a patient who was not Medicaid eligible in the DMHMRSAS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

**E. 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**

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.

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 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.

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; I688B-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, <i>other than Cuban or Haitian Entrants</i> , 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

	<i>UNQUALIFIED ALIEN GROUPS</i>	Arrived Before 8-22-96	Arrived On or After 8-22-96	
<i>K</i>	Aliens residing in the US pursuant to an indefinite stay of deportation [I-94; Immigration Letter]	Emergency Only <i>K1</i>	Emergency Only <i>K2</i>	Emergency Only <i>K3</i>
<i>L</i>	Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter]	Emergency Only <i>L1</i>	Emergency Only <i>L2</i>	Emergency Only <i>L3</i>
<i>M</i>	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 <i>M1</i>	Emergency Only <i>M2</i>	Emergency Only <i>M3</i>
<i>N</i>	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 <i>N1</i>	Emergency Only <i>N2</i>	Emergency Only <i>N3</i>
<i>O</i>	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 <i>O1</i>	Emergency Only <i>O2</i>	Emergency Only <i>O3</i>
<i>P</i>	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 <i>P1</i>	Emergency Only <i>P2</i>	Emergency Only <i>P3</i>
<i>Q</i>	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 <i>Q1</i>	Emergency Only <i>Q2</i>	Emergency Only <i>Q3</i>
<i>R</i>	Aliens residing in the U.S. under orders of supervision [I-220B]	Emergency Only <i>R1</i>	Emergency Only <i>R2</i>	Emergency Only <i>R3</i>
<i>S</i>	Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record]	Emergency Only <i>S1</i>	Emergency Only <i>S2</i>	Emergency Only <i>S3</i>

M0270.000 APPLICATION FOR OTHER BENEFITS**M0270.100 GENERAL PRINCIPLE****A. Policy**

Because Medicaid is a “last pay” medical assistance program, it is important that the individual and agency worker assess the other benefits for which an individual is eligible based on his or her own activities or based on indirect qualification through family circumstances.

As a condition of eligibility, an individual must take all necessary steps to apply for and obtain any annuities, pensions, retirement, and disability benefits to which he/she is entitled, unless he/she can show good cause for not doing so.

1. Steps to Pursue Other Benefits

An individual must take all appropriate steps to pursue eligibility for other benefits. This includes

- applying for the benefit, and
- providing the source of the other benefit with the necessary information to determine the individual’s eligibility for the benefit.

2. Refusal To Apply

Refusal to apply for a benefit or refusal to accept a benefit to which the individual is entitled will result in the inability of a local agency to determine the individual’s Medicaid eligibility.

In the case of a minor or an incapacitated individual, a parent or other responsible person must pursue benefits for which the minor or the incapacitated individual might be entitled. If such benefits are not pursued, eligibility must be denied.

A non-applicant parent or spouse cannot be required to apply for any benefit on their own behalf. A child’s or spouse’s Medicaid eligibility cannot be denied due to the failure of the non-applicant parent or spouse to apply for or accept a benefit for which the non-applicant parent or spouse might be entitled.

3. Good Cause For Not Applying

An individual meets this requirement for Medicaid, despite failure to apply for other benefits or take other steps necessary to obtain them, if the individual has good cause for not doing so. For example, good cause exists if:

- the individual is unable to apply for other benefits because of illness;
- it would be useless to apply because the individual had previously applied and the other benefit source turned him down for a reason(s) that has not changed;
- it would result in no additional benefit which would affect the individual’s Medicaid eligibility or amount of Medicaid services.

B. Procedure The types of benefits for which an individual must apply and/or accept are listed in section M0270.200 below.

The procedures to follow are in section M0270.300 below.

M0270.200 TYPES OF BENEFITS

A. Benefits Excluded From Requirement to Apply An applicant is NOT required to apply for benefits or assistance that is based on the individual's need. An individual is not required to apply for cash assistance program benefits such as Supplemental Security Income (SSI) or Temporary Assistance For Needy Families (TANF).

Payments such as child support, alimony, accelerated life insurance, etc., are NOT benefits for which an individual must apply.

B. Types of Benefits For Which An Individual Must Apply

1. Benefit Characteristics

Benefits for which the individual must apply have the following characteristics in common:

- require an application or similar action;
- have conditions for eligibility;
- make payments on an ongoing or one-time basis.

2. Major Benefit Programs

Annuities, pensions, retirement and disability benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

- a. Veterans' Compensation and Pensions, including apportionment of augmented dependents' benefits;
- b. Social Security Title II Benefits (OASDI - Old Age, Survivors & Disability Insurance)
- c. Railroad Retirement Benefits
- d. Unemployment Compensation
- e. Worker's Compensation
- f. Black Lung Benefits
- g. Civil Service and Federal Employee Retirement System Benefits
- h. Military Pensions

3. Other Benefits

Other benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

- a. private insurance company disability, income protection, etc., benefits when the individual has such a policy;
- b. private pension plan benefits;
- c. union benefits.

M0270.300 AGENCY PROCEDURES**A. Written Notice**

The local agency Eligibility Worker (EW) must advise the individual in writing on a dated notice that the individual must apply for other benefits for which he or she is potentially eligible. The written notice must list the benefits for which the individual must apply.

B. Identify Potential Eligibility For Other Benefits

Obtain clues to an individual's possible eligibility for other benefits from:

- information obtained from the interview, including responses to leading questions on the application;
- the recipient's responses on a redetermination form and/or interview;
- inquiries received from another agency;
- agency knowledge of pension plans and benefits;
- third party reports;
- computer system inquiries.

C. Disability Referral Processing

Do not hold the *Disability Determination Services (DDS)* referral while waiting for the applicant to provide proof of his/her application for disability benefits; send it immediately to the *DDS*.

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

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

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

B. Aged

“Aged,” means age 65 years or older.

C. Procedures

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

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

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

M0310.106 BLIND**A. Definition**

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

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

B. Procedures

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

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

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

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

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

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

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

**2. Specified
Degree**

A relative of specified degree of the dependent child is

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

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

B. Procedures**1. Relationship**

The relationship as declared on the application/redetermination form is used to determine the caretaker-relative's relationship to the child. No verification is required.

**2. Living in the
Home**

A child's presence in the home as declared on the application/redetermination form is used to determine if the child is living in the home with a parent or a caretaker-relative. No verification is required.

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M0310.108 CATEGORICALLY NEEDY (CN & CNNMP)**A. CN Definition**

"CN" is the short name for "categorically needy." CN is one of the two federal classifications of Medicaid covered groups. The CN covered groups in Virginia include the mandatory cash assistance categorically needy groups listed in the federal Medicaid regulations. "Mandatory" groups are groups of individuals that a state's Medicaid state plan must cover.

A categorically needy (CN) individual is one who is eligible for and usually receiving some type of cash assistance (money payment), or is deemed to be a cash assistance recipient, and is not precluded from eligibility because of a property transfer that occurred prior to July 1, 1988.

**B. CNNMP
Definition**

"CNNMP" is the short name for "categorically needy non money payment." CNNMP is the name Virginia uses for the federal "optional" categorically needy covered groups and the mandatory categorically needy covered groups that do not receive cash assistance. "Optional" means the state can choose whether or not to cover a particular group of individuals in its state plan.

A CNNMP individual is one who is not receiving a cash assistance money payment and is usually not eligible for cash assistance, but who meets the requirements of a CNNMP covered group and is not precluded from eligibility because of a property transfer that occurred prior to July 1, 1988.

C. Procedures

See subchapter M0320 for the policy and procedures to use to determine if an individual meets a categorically needy or CNNMP covered group.

M0310.109 COVERED GROUP

A. Definition

The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as categorically needy (CN), categorically needy non money payment (CNNMP), medically indigent (MI) and medically needy (MN). The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

B. Procedure

The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

M0310.110 CHILD

A. Definition

An individual under age 21 years who has not been legally emancipated from his/her parent(s) is a child.

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

M0310.111 DEPENDENT CHILD

A. Definition

The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a needy child who is:

1. under the **age of 18**, or under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in a *General Educational Development (GED) program* IF he may be reasonably expected to *complete the secondary school, training or program* before he attains age 19; and
2. **living in the home of a parent or a caretaker-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. *See section M0310.107 for the definition of a caretaker-relative.*

B. Age & School Enrollment

1. Age

The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency AND is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

2. School Enrollment

Accept the declaration of school enrollment.

C. Living With a Parent or Caretaker-Relative

1. Relationship

The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.

For the purpose of determining a relationship, neither death, divorce, nor adoption terminates relationship to the biological relatives.

2. Living in the Home

A child's presence in the home as declared on the application/redetermination is used to determine if the child is living in the home with a parent or caretaker-relative. No verification is required.

A child who is living away from the home is considered living with his parents in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as vacation, visit, education, rehabilitation, placement in a facility for less than 30 days) is complete.

NOTE: If the stay in the medical facility has been or is expected to be 30 days or more, go to M1410.010 to determine if the child is institutionalized in long-term care.

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

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

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SUBCHAPTER

M0310.112 DISABLED

A. Introduction

The Social Security Administration (SSA) defines disability for an individual who is age 18 or older as the inability to do any substantial gainful activity (work) because of a severe, medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 continuous months, or which is expected to result in death.

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

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

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

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

B. Policy

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

C. Who Meets the Medicaid Disability Definition

An individual meets the Medicaid disability definition if he:

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

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

E. Enrollment

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

The PD for MI newborns is “93.”

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

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

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

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

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

Retroactive coverage is available for FPS.

B. Nonfinancial Requirements

Women in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02:

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

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

C. Financial Eligibility

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

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

An income eligibility determination is required for:

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

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

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

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

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

B. Policy

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

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

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

1. Member In One Unit

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

2. May Exclude A Child

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

3. Living Away From Home

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

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

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

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

C. Procedure

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

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

M0520.010 DEFINITIONS

A. Introduction

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

B. Acknowledged Father

A male individual who is not married to the mother is an acknowledged father if any of the following exist:

- the man has been found by a court to be the child's father;
- the man has admitted paternity either before a court, or voluntarily in writing, under oath;
- the man has been found by a blood test to be the child's father;
- the man's name appears on the child's official birth certificate;
- the child has been placed by a court with the man or a relative of the man on the basis that he is the child's father.

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**LIFC 185% OF STANDARDS OF NEED (MAXIMUM MONTHLY INCOME)
EFFECTIVE 7/01/04**

FAMILY/BUDGET UNIT SIZE	GROUP I	GROUP II	GROUP III
1	\$ 292.82	\$ 348.99	\$ 487.37
2	459.30	515.46	655.85
3	591.67	645.85	788.25
4	718.05	774.21	916.61
5	846.42	916.61	1087.11
6	948.70	1020.91	1189.40
7	1073.07	1143.27	1313.76
8	1207.46	1275.66	1444.21
9	1317.77	1387.99	1562.48
10	1440.15	1512.35	1682.77
Each person above 10	122.33	122.33	122.33

F&C Monthly Income Limits Effective 7/01/04

Group I

Family/Budget Unit Size	100%	90%
1	158.28	142.02
2	248.27	224.42
3	319.82	287.30
4	388.14	349.11
5	457.53	411.99
6	512.81	462.95
7	580.04	522.58
8	652.68	586.54
9	712.31	640.75
10	778.46	701.47
Each person above 10	66.13	60.70

Group II

Family/Budget Unit Size	100%	90%
1	188.65	170.21
2	278.63	250.44
3	349.11	315.49
4	418.49	376.20
5	495.47	443.47
6	551.85	496.56
7	617.99	555.10
8	689.55	620.16
9	750.27	675.45
10	817.49	735.08
Each person above 10	66.13	60.70

F&C Monthly Income Limits Effective 7/01/04

Group III

Family/Budget Unit Size	100%	90%
1	263.44	238.52
2	354.52	318.75
3	426.08	383.80
4	495.47	444.52
5	587.63	529.09
6	642.92	578.95
7	710.14	639.67
8	780.65	704.73
9	844.59	760.02
10	909.60	818.56
Each person above 10	66.13	60.70

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MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7-01-04

# of Persons In Family/ BudgetUnit	GROUP I		GROUP II		GROUP III	
	Semi- Annual Income	Monthly Income	Semi- Annual Income	Monthly Income	Semi- Annual Income	Monthly Income
1	\$1409.47	\$234.91	\$1626.31	\$271.05	\$2114.20	\$352.36
2	1794.91	299.15	2002.90	333.81	2549.20	424.86
3	2114.20	352.36	2331.05	388.50	2873.15	478.85
4	2385.26	397.54	2602.10	433.68	3144.20	524.03
5	2656.31	442.71	2873.15	478.85	3415.26	569.21
6	2927.36	487.89	3144.20	524.03	3686.31	614.38
7	3198.41	533.06	3415.26	569.21	3957.36	659.56
8	3523.68	587.28	3740.52	623.42	4228.41	704.73
9	3848.94	641.49	4065.78	677.63	4607.89	767.98
10	4228.41	704.73	4445.26	740.87	4933.15	822.19
each add'l person add	364.29	60.71	364.29	60.71	364.29	60.71

FAMILIES & CHILDREN EARNED INCOME EXCLUSIONS

EXCLUSION	CRITERIA	LIMITATIONS
Workforce Investment Act M720.505	child < age 19	none
Student Earnings M720.510	child < age 19 in school	none
\$90 Standard Work M720.520	available for EACH person in the FU/BU whose earnings are being counted	not allowed in 185% screening for LIFC
\$30 plus 1/3 (LIFC only) M720.525	<p>applicants must have received LIFC Medicaid in at least one of the preceding 4 months</p> <p>can be allowed until exclusion has been received for 4 consecutive months</p> <p>once received for 4 consecutive months cannot allow again until person has not been enrolled in Medicaid in a LIFC covered group for 12 consecutive months</p>	<p>not allowed in 185% screening for LIFC</p> <p>4 consecutive months</p>
\$30 (LIFC only) M720.526	allowed immediately following the \$30 plus 1/3 exclusion	<p>not allowed in 185% screening for LIFC</p> <p>fixed 8-month period</p>
Child Care/ Incapacitated Adult Care M720.540	<p>allowed for child or adult in FU/BU</p> <p>amount based on employment status of applicant/recipient and age of child or adult</p> <p>= or >30 hours/week or 120 hours/month <2 years= \$200 maximum per child >2 years= \$175 maximum per child or adult</p> <p>< 30 hours/week or 120 hours/month \$120 per child or adult</p>	<p>not allowed in 185% screening for LIFC</p> <p>allowed as long as child or adult is in FU/BU</p>

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applicant/recipient and the responsible person, must be counted as unearned income to the child. The \$50 disregard is NOT applicable to third party payments.

M0730.500 DIVIDENDS AND INTEREST

- A. Policy** *Dividends and interest are only counted as unearned income when earned on a countable resource. Dividend and interest income payments on countable resources are counted as income in the month received or anticipated to be received (even if paid quarterly, annually, etc.), unless the interest is earned on an excluded savings account for education, home purchase or establishing a business per M0630.125.*
- B. Definition** Dividends and interest are returns on capital investments such as stocks, bonds, certificates of deposit, or savings accounts.
- C. Procedure** Verify the amount that is received or is anticipated to be received by documents in the applicant/recipient's possession or through contact with the financial institution where the account or other financial instrument is located.

M0730.505 RENTAL/ROOM AND BOARD INCOME

- A. Policy** Net rental/boarder income from the rental of real property, or rooms, or board paid when the applicant/recipient is not engaged in a business enterprise or actively involved in management is unearned income. Rental/room and board income is counted in the month in which it is received.
- B. Definitions**
- 1. Rent** Rent is a payment which an individual received for the use of real or personal property, such as land or housing.
 - 2. Net Rental Income** Net rental income is the total amount received less the allowable costs.
 - 3. Board** Board is the amount paid for the provision of meals only.
 - 4. Room** Room is the amount paid to rent a room only.
 - 5. Room and Board** Room and board is the amount paid for room rent and the provision of meals.

C. Calculation of Net Rental/Boarder Income

1. Real or Personal

The net rental income is the total amount received less the tax on the property.

Verify the anticipated income by documents in the applicant's possession or by a statement from the tenant.

Verify the anticipated cost by a tax receipt for the property owned.

2. Room Rent

The net rental income is 65% of the total rent received if heating fuel is furnished by the applicant/recipient. The net rental income is 75% of the total rent received if heating fuel is not furnished.

Verify the rent paid by documents in the applicant/recipient's possession or a statement from the tenant.

3. Boarders

The net rental income is the total board received less the standard food allowance for one person at 100% per boarder. *Contact your Medicaid Consultant for the current standard food allowance.*

Verify anticipated income from documents in applicant/recipient's possession or statement from boarder.

4. Roomer/Boarders

The net rental income is the total rent received less the standard food allowance for one person at 100% per boarder AND the room rental costs: 65% of the total rent received if heating fuel is furnished or 75% of the total rent received if heating fuel is not furnished.

Verify anticipated income by documents in the applicant/recipient's possession or by a statement from the boarder.

M0730.520 GIFTS

A. Policy

The first \$30 received by each individual in the assistance unit per calendar quarter for special occasions, such as birthdays, Christmas, etc., is excluded.

B. Definition

Calendar quarters are:

January - March;

April - June;

July - September;

October - December.

C. Procedure

Any amount in excess of the \$30 per calendar quarter anticipated to be received will be counted as unearned income in the month in which it is anticipated to be received.

M0730.522 CONTRIBUTIONS**A. Policy****1. Contribution from agencies or organization**

Any cash contribution made directly to the FU/BU by an agency or organization must be counted as unearned income to the FU/BU if such contribution is for any of the following:

- food, including special diets
- clothing
- personal care
- household supplies and equipment
- insurance
- school supplies and expenses
- laundry
- utilities (including telephone)
- housekeeping and personal services
- obligations incurred within the month of application
- guardianship fees
- average shelter costs appropriate to the locality in which the assistance unit resides (including rent, house payments, taxes, fire or comprehensive insurance repairs, installations, water sewage and trash disposal)

NOTE: If the contribution to the assistance unit is for one of the items listed above, it is unearned income and counted dollar for dollar. If it is not for one of the items listed above, it is not unearned income.

2. All Other Cash Contributions

All other cash contributions are counted in amount received as unearned income.

B. Procedure

- Verify with the administering agency or person contributing, the purpose of the contribution; AND
- Verify the amount of the contribution.

M0730.600 HOME ENERGY ASSISTANCE**A. Policy**

Payments made directly to a household for home heating or cooling provided by suppliers of home energy, such as electric and gas companies and fuel oil dealers, must be counted as income.

B. Value of Assistance

When payments are received jointly by a household composed of Medicaid and non-Medicaid applicants/recipients, the FU/BU's pro rata share, based on the total number of persons in the household, must be considered as unearned income to the Medicaid FU/BU.

M0730.800 TREATMENT OF LUMP SUM INCOME**A. Policy**

The receipt (on or after the month of application for Medicaid) of a nonrecurring lump sum payment is counted as income of the individual who received it. It is counted as income to the individual who received it in the month of receipt. If any of the lump sum is retained beyond the month of receipt, the retained portion is counted as a resource to the individual.

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 category/classification; and
 - meets the nonfinancial requirements; and
 - meets the classification's resource limits; and
 - meets the classification'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 classification 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 classification.

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

<ul style="list-style-type: none"> • Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits 	
Family Unit Size	Monthly Amount
1	\$564
2	846
<ul style="list-style-type: none"> • For individual or couple whose total food and shelter needs are contributed to him or them 	
Family Unit Size	Monthly Amount
1	\$375.62
2	563.94

**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.

<ul style="list-style-type: none"> Categorically Needy-Non Money Payment 300% of SSI 	
Family Size Unit 1	Monthly Amount \$1,692

**4. Medically
Needy**

a. Group I		
Family Unit Size 1	Semi-annual \$ 1,409.47	Monthly \$ 234.91
2	1,794.91	299.15
b. Group II		
Family Unit Size 1	Semi-annual \$ 1,626.31	Monthly \$ 271.05
2	2,002.90	333.81
c. Group III		
Family Unit Size 1	Semi-annual \$ 2,114.20	Monthly \$ 352.36
2	2,549.20	424.86

**5. ABD
Medically
Indigent**

**For:
ABD 80%
FPL, QMB,
SLMB, & QI
without Social
Security (SS)
and QDWI,
effective
2/13/04; and
ABD 80%
FPL, QMB,
SLMB, & QI
with SS,
effective 4/1/04**

ABD 80% FPL 1	Annual \$ 7,448	Monthly \$ 621
2	9,992	833
QMB 100% FPL 1	Annual \$ 9,310	Monthly \$ 776
2	12,490	1,041
SLMB 120% of FPL 1	Annual \$11,172	Monthly \$ 931
2	14,988	1,249
QI 135% FPL 1	Annual \$12,569	Monthly \$1,048
2	16,862	1,406
QDWI 200% of FPL 1	Annual \$18,620	Monthly \$1,552
2	24,980	2,082

4. Contact with OPM

If the individual has no acceptable documents, write or telephone OPM. Provide the individual's name and civil service annuity claim identification number (a seven-digit number with a "CSA" or "CSF" prefix). If the claim number is not available, provide the individual's date of birth and Social Security number.

The OPM telephone number is (888) 767-6738. Direct written inquiries to:

*U.S. Office Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017*

S0830.225 RAILROAD RETIREMENT PAYMENTS

A. Introduction

1. Categories of Payment

There are three basic categories of payments made by the Railroad Retirement Board (RRB):

- Life and survivor annuities
- Social Security benefits certified RRB
- Unemployment, sickness, and strike benefits

2. Life and Survivor Annuities

- Life annuities for retirement and disability are paid under the Railroad Retirement (RR) Act to the railroad employee and his/her spouse. Children of a living annuitant are not entitled to benefits.
- Survivor annuities are payable to widows, widowers, children, and dependent parents of railroad employees. A small number of widows receive two annuities, a regular widow's check and a check payable to them as designated survivors of retired railroad employees who elected to receive reduced benefits during their lifetimes.
- RR annuity payments are similar to Title II benefits in that a check for one month is paid the next month. Also, cost of living adjustments (COLA) for RR annuities are effective the same month as Title II COLA's.

3. Social Security Benefits Certified by RRB

SSA may authorize the payment of Social Security benefits for RR employees to RRB instead of directly to Treasury. Although RRB in these situations has responsibility for certifying Title II benefits to Treasury, they remain Title II benefits.

Individuals entitled to this type of benefit receive two award notices. The first notice, from SSA, informs the beneficiary that RRB has responsibility for making Social Security payments. The final notice, from RRB, specifies the amount of the first check.

RR annuity payments and Social Security benefits certified by RRB may be paid as a single check. In these cases, RRB may issue an interim notice before the final notice which specifies the amount of the first check.

**4. Unemployment
Sickness, and
Strike Benefits**

Unemployment, sickness, and strike benefits are computed on a daily basis with each check covering a period of up to 2 weeks. These claims are usually filed through the railroad employer or directly with RRB in Chicago.

B. Policy

**1. Unearned
Income**

Payments made by the RRB are unearned income.

**2. Reduction of
RR Benefits**

The amount deducted from a RR benefit for supplementary medical insurance (SMI) premiums is unearned income. See S0830.110 if an overpayment is involved.

**3. Countable RR
Income**

The amount of the RR annuity to count as income is the amount before the collection of any obligations of the annuitant (unless the exception in S0830.110 applies).

**C. Procedure - Life
and Survivor
Annuities**

**1. General
Development --
All Cases**

a. Be alert to the possibility of the receipt of, or potential entitlement to, RR benefits in every case where:

- the individual's social security number begins with a "7"
- the individual alleges or other evidence indicates railroad employment by the individual or his/her spouse.

b. Verify allegations of receipt of RR annuities by obtaining a copy of the individual's most recent award notice.

c. If the notice is unavailable, record in the file the information from the individual's next check.

NOTE: RR checks bear beneficiary symbols that identify the type of RR benefit involved.

**D. Procedure Social
Security Benefits
Certified By RRB**

Follow the instructions in S0830.210.C. for documentation of Social Security benefits certified by RRB. (The notice issued by RRB which specified the amount of the first check is one form of evidence.)

**E. Procedure -
Unemployment,
Sickness, and
Strike Benefits**

Obtain evidence of unemployment, sickness, and strike benefits from the individual's own records, such as an award letter or actual check. If this evidence is unavailable, contact RRB headquarters in Chicago at:

Railroad Retirement Board
844 Rush Street
Chicago, IL 60611

Local RRB offices do not maintain this information.

PERSONAL PROPERTY

M1130.200 AUTOMOBILES

A. Policy Principles

1. **Automobile Defined** For ABD Medicaid purposes, "automobile" means any vehicle used for transportation. It thus can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and even animals.
2. **Current Market Value Defined** The CMV of an automobile is the average trade-in value listed in the NADA Guide.
3. **Exclusion Regardless of Value** Ownership of one motor vehicle does not affect eligibility. One automobile, regardless of value, is excluded for the individual or a member of the individual's household.
4. **Other Automobiles** Any automobile an individual owns in addition to the one excluded will be evaluated as a countable resource.
5. **Rebuttal of NADA Value** *If the individual disagrees with the NADA value, the individual must be given the opportunity to rebut it. Rebuttal evidence consists of one written appraisal for the automobile's value from a knowledgeable source, such as a used vehicle dealer or an automobile insurance company.*

B. Operating Policy-- More than One Automobile Owned

1. **General Rule** If more than one automobile is owned, one automobile will be excluded and the other will be a countable resource. The exclusion will apply to the automobile with the highest equity value.
2. **Determining Equity Value** Use the following method to determine equity value:
 - Determine the average trade-in value for each automobile from the NADA Guide. In the event the automobile is not listed, the value assessed by the locality for tax purposes may be used.
 - Determine the equity value in each automobile by subtracting the debt from NADA value.
 - Exempt the automobile with the highest equity value.
3. **References** See M1110.400 for what values apply to resources.
See Appendix 1 for QDWI development.

M1130.300 LIFE INSURANCE

A. Definitions

1. **Life Insurance Policy** A life insurance policy is a contract. Its purchaser (the owner) pays premiums to the company that provides the insurance (the insurer). In return, the insurer

agrees to pay a specified sum to a designated beneficiary upon the death of the insured (the person on whom, or on whose life, the policy exists).

2. Face Value

Face value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such, or as the "amount of insurance", "the amount of the policy," "the sum insured," etc. A policy's FV does not include:

- the FV of any dividend addition, which is added after the policy is issued (see 5. below);
- additional sums payable in the event of accidental death or because of other special provisions; or
- the amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other(s).

3. Cash Surrender Value

A policy's cash surrender value (CSV) is a form of equity value that it *accrues* over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV.

4. Dividends

Periodically (annually, as a rule), the insurer may pay a share of any surplus company earnings to the policy owner as a dividend.

Depending on the life insurance company and type of policy involved, dividends can be applied to premiums due or paid by check or by an addition or accumulation to an existing policy.

5. Dividend Additions and Accumulations

a. Additions

Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV.

The table of CSV's that comes with a policy does not reflect the added CSV of any dividend additions.

b. Accumulations

Dividend accumulations are dividends that the policy owner has constructively received but left in the custody of the insurer to accumulate as interest, like money in a bank account. They are not a value of the policy per se; the owner can obtain them at any time without affecting the policy's FV or CSV.

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision (e.g., as set aside for burial), they are a countable resource.

M1140.110 OTHER PROPERTY RIGHTS

A. Introduction

1. **Mineral Rights** Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.
2. **Timber Rights** Timber rights permit one party to cut and remove free standing trees from the property of another property.
3. **Easements** An easement gives one party the right to use the land of another party for a special purpose.
4. **Leaseholds** A leasehold gives one party control over certain property of another party for a specified period. In some States, a "lease for life" can create a life estate under common law.
5. **Water Rights** Water rights usually confer upon the owner for riverfront or storefront property the right to access and use the adjacent water.
6. **Life Estates** A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage.

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

Life rights to real property are not counted as a resource, except for QDWI (see Appendix 1 to chapter S11).
7. **Remainder Interests** When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property.

B. Development and Documentation

1. General

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

2. Mineral Rights

a. Ownership of Land and Mineral Rights

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

b. Ownership of Mineral Rights Only

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

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

3. Lease for Life

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

4. Value of Life Estate or Remainder Interest

a. General

Using the table in S1140.120, multiply the CMV of the property by the life estate or remainder interest decimal that corresponds to the individual's age. Record the result.

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

b. Life estate in real property is not a resource for an applicant or recipient, except for QDWI (see Appendix 1 to chapter S11).

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

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

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

before July 1, 1988, the resource transfer could still affect his/her current Medicaid eligibility.

B. Procedure

If the individual reports a property transfer that occurred before July 1, 1988, contact your Regional Specialist for instructions. The individual may still be in an ineligibility period because of the property transfer.

M1450.200 TRANSFERS ON/AFTER JULY 1, 1988 BUT BEFORE AUGUST 11, 1993

A. Policy

The policy governing resource transfers that occurred on or after July 1, 1988 but before August 11, 1993 differs from policy governing transfers on or after 8-11-93. This rule could have affected an individual's eligibility for Medicaid payment of LTC services if the transfer was uncompensated and not allowed by policy. The maximum ineligibility period under this rule is 30 months from the date the transfer occurred.

The maximum penalty period for transfers under this rule expired on March 1, 1996. Therefore, transfers which occurred on/after 7-1-88 but before 8-11-93 can no longer affect eligibility.

B. Procedure

If the individual reports that a property transfer occurred on or after 7-1-88 but before 8-11-93, document in the case record:

- the transfer date
- that the transfer no longer affects eligibility because the maximum penalty period for transfers that occurred on/after 7-1-88 but before 8-11-93 expired on 3-1-96.

M1450.300 SPOUSE-TO-SPOUSE TRANSFERS ON/AFTER JANUARY 1, 1989 BUT BEFORE OCTOBER 1, 1989

A. Policy

Spouse-to-spouse transfers that occurred on or after July 1, 1988 but before January 1, 1989 do not affect eligibility.

Spouse-to-spouse resource transfers that occurred **on or after January 1, 1989 but before October 1, 1989 affect eligibility.**

The policy governing spouse-to-spouse resource transfers that occurred on or after January 1, 1989 but before October 1, 1989 differs from policy governing transfers on or after 10-1-89. This rule can affect an individual's eligibility for **all** Medicaid services if the transfer was uncompensated and was not allowed by policy.

However, in order to have had an penalty period under this rule affect current eligibility, the individual must have applied for Medicaid at least

once before April 1, 1992. If the individual applied for Medicaid before April 1, 1992, and reported a resource transfer that was made on or after January 1, 1989 but before October 1, 1989, the resource transfer could still affect his/her current Medicaid eligibility.

B. Procedure

If the individual reports a property transfer to his/her spouse that occurred on or after 1-1-89 but before 10-1-89, contact your *Medicaid Consultant* for instructions. The individual may still be in an ineligibility period because of the property transfer.

M1450.400 SPOUSE-TO-SPOUSE TRANSFERS ON/AFTER OCTOBER 1, 1989 BUT BEFORE AUGUST 11, 1993**A. Policy**

The policy governing spouse-to-spouse resource transfers that occurred on or after October 1, 1989 but before August 11, 1993 differs from policy governing spouse-to-spouse transfers on or after 8-11-93. This rule could have affected an individual's eligibility for Medicaid payment of LTC services if the transfer was uncompensated and not allowed by policy. The maximum ineligibility period under this rule is 30 months from the date the transfer occurred.

The maximum penalty period for transfers under this rule expired on March 1, 1996. Therefore, spouse-to-spouse transfers which occurred on/after 10-1-89 but before 8-11-93 can no longer affect eligibility.

M1450.500 TRANSFERS ON OR AFTER AUGUST 11, 1993**A. Policy**

An institutionalized individual who disposes of, or whose spouse disposes of, assets for less than fair market value on or after the look-back date specified in subsection B below is ineligible for Medicaid payment of LTC services (nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home or community-based services furnished under a CBC waiver). This rule applies to asset transfers occurring on or after August 11, 1993.

Once an individual has established eligibility for Medicaid payment of LTC services, transfer of assets owned by the community spouse do not affect the institutionalized spouse's Medicaid eligibility.

NOTE: The definition of an institutionalized individual for asset transfer purposes differs from the definition for the other Medicaid eligibility requirements. See M1450.003 above for the definition of an institutionalized individual for asset transfer purposes.

B. Procedures

When an enrolled Medicaid recipient is institutionalized, review his/her eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant.

Take the following actions to determine if an asset transfer affects eligibility for Medicaid payment of long-term care services:

1. Transfers Not Involving Trusts

Determine if any assets of the individual or the individual's spouse were transferred during the 36 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

2. Transfers Involving Trusts

Determine if any of the individual's or the individual's spouse's assets were transferred into or from a trust fund during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

3. Determine Effect

If an asset was transferred during any of the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.501 through M1450.604 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.701) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.702).

M1450.501 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER RULE

A. Policy

The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.

B. Personal Effects and Household Items

A transfer of personal effects or household items does not affect eligibility. Personal effects and household items are:

- an engagement ring;
- a wedding ring;
- items required by an individual's medical or physical condition; and
- household goods and personal effects that are not items of unusual value.

An item of unusual value is:

- one that has a fair market value of more than \$1000 or
- two or more items, when each has a fair market value of \$500 or more.

NOTE: Transfer of an item of unusual value affects eligibility for payment of LTC services.

C. Certain Vehicles

The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:

- A vehicle used by the applicant/recipient to obtain medical treatment.
- A vehicle used by the applicant/recipient for employment.
- A vehicle especially equipped for a disabled applicant or recipient.
- A vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, \$4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of \$4,500 must be evaluated as an asset transfer.

D. Property Essential to Self Support

The transfer of property essential to the institutionalized individual's self-support (tools, equipment, etc. used by the individual to produce income), including up to \$6,000 equity in income-producing real property(ies) owned by the applicant/recipient, does not affect eligibility for LTC services' payment.

To be income-producing, the property(ies) must usually have a net annual return that is:

- 6% of the equity, if the equity is \$6,000 or less or
- \$360 if the equity is more than \$6,000.

If an unusual circumstance caused a temporary reduction in the net annual return and the net annual return is expected to meet the requirements the following year, the property is still considered income-producing.

- 4. Cross-reference** If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item 3 above, go to M1450.603 below to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, 1120.201 and 1120.202.

D. Intention to Receive Adequate Compensation

Transfer of any asset does not affect eligibility for LTC services' payment if the individual shows that he/she intended to receive adequate compensation for the asset or that he/she actually received adequate compensation for the asset for LTC services' payment. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below.

1. Evidence of Reasonable Effort to Sell

The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.

2. Evidence of Legally Binding Contract

The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.601 below.

3. Burial Trust of \$2,500 or Less

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust of \$2,500 or less and that the burial trust was established before July 1, 1988. The trust is adequate compensation for the transferred asset.

Thus, transfer of \$2,500 or less into an irrevocable burial trust before July 1, 1988, will not affect Medicaid payment for LTC services.

4. Burial Trust of Over \$2,500

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust of over \$2,500, and that the burial trust was established on or after July 1, 1988. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, 1120.201 and 1120.202.

E. Reason Exclusive of Becoming or Remaining Medicaid-Eligible

Transfer of any asset does not affect eligibility if the asset was transferred for a reason **exclusive** of becoming or remaining eligible for Medicaid LTC services' payment.

1. The individual must provide objective evidence that the transfer exclusively for another purpose(s) and the reason(s) for the transfer did not include possible or future Medicaid eligibility.
2. A subjective statement of intent or ignorance of the asset transfer provision is not sufficient. The individual could, for example, provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

F. Post-Eligibility Transfers by the Community Spouse

Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.

G. Return of Asset

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

H. Undue Hardship Policy

The transfer of an asset for less than fair market value does not affect eligibility if ineligibility for Medicaid payment of long-term care services would work an undue hardship on the individual.

1. Hardship Claim

The local agency worker must inform each institutionalized applicant or recipient of the asset transfer "undue hardship" policy provision. The applicant must be given the form "Asset Transfer Hardship Claim" (M1450.900) upon which he/she:

- checks whether he does or does not claim undue hardship, and
- if he claims undue hardship, states the reason(s) that ineligibility for Medicaid payment of long-term care services would work an undue hardship on him/her.

2. Hardship Evaluation Form

If the individual does not claim undue hardship, the worker does not evaluate the transfer under the undue hardship policy.

If the individual claims undue hardship, the worker must evaluate the undue hardship claim using the evaluation form in M1450.901 at the end of this subchapter, and the evaluation criteria in item 3 below.

The transferred assets, the date each was transferred, and the evaluation criteria must be noted on the form.

3. Evaluation Criteria

a. Other Resources Available

Were other resources available? Documentation should include a notarized statement indicating all resources owned by the individual at the time of transfer.

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

M1470.001 OVERVIEW

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

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

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

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

Because the new resources that Mrs. Tree received plus all other resources in her name, less the CSRA balance, do not exceed the resource limit, her Medicaid eligibility continues until April 15, 1998, the end of the protected period. All of Mrs. Tree's resources will be counted available to her beginning April 16, 1998, the day after the protected period ends.

G. Community Spouse Acquires Additional Resources During Protected Period

If the **community spouse** obtains additional resources during the protected period of eligibility, the institutionalized spouse's eligibility is NOT affected. The community spouse's new resources are not counted when determining the institutionalized spouse's eligibility during or after the protected period of eligibility. **Do NOT recalculate the CSRA.**

H. Reviewing Resource Eligibility

When reviewing the institutionalized spouse's resource eligibility at the end of the protected period and at scheduled redeterminations, the community spouse's resources are NOT counted available.

I. Asset Transfers

Instructions for treatment of asset transfers are found in subchapter M1450.

J. Example-- Re-application, No Protected Period

EXAMPLE #13: Mr. Apple is institutionalized in a nursing facility; he was admitted on January 28, 1998. Mrs. Apple is his community spouse. The first day of the first month of the first continuous period of institutionalization is January 1, 1998. Mr. Apple applied for Medicaid on February 5, 1998.

Step 1:

The couple's total resources on January 1, 1998 were \$86,640.

Step 2:

$\$86,640 \div 2 = \$43,320$. The spousal share is \$43,320.

Step 3:

The couple's total resources as of the application month were \$45,320.

Step 4:

The PRA was determined. It is the greater of:

- \$43,320 (the spousal share which is less than the maximum spousal resource standard of \$80,760 at application),
- \$16,152 (the spousal resource standard at application),
- \$ 0 (amount designated by DMAS Hearing Officer),
\$ 0 (amount transferred pursuant to court support order)

\$43,320 is the PRA.

Step 5:

\$45,320	Step 3 couple's resources at application
<u>- 43,320</u>	PRA
\$ 2,000	countable to Mr. Apple in application month

Steps 6 & 7:

Mr. Apple's resources equal the resource limit, so he is resource eligible.

Since his income is within the Medicaid income limit, he is eligible for Medicaid in the application month.

Step 8a: Mrs. Apple owns \$20,000, in her name only, plus \$8,320 (one-half share of jointly owned resources); a total of \$28,320 of the couple's resources are available to Mrs. Apple.

Step 8b: Mr. Apple's resources at application were \$8,680 in his name only and ½ the jointly owned account of \$16,640, or \$8,320. Total = \$17,000.

Step 9: Because Mr. Apple is eligible in the February 1998 application month, the community spouse resource allowance (CSRA) is calculated to determine Mr. Apple's ongoing eligibility:

\$43,320 PRA
- 28,320 community spouse's resources
\$15,000 CSRA

Step 10: \$17,000 institutionalized spouse's resources
- 15,000 CSRA
2,000 countable resources

Steps 11 & 12: Mr. Apple's resources equal the limit and he remains eligible because he expressed, in writing, his intention to transfer his excess resources to Mrs. Apple. His resource eligibility is protected for 90 days beginning February 25, 1998, the date the agency took action to approve the application, and ending May 24, 1998.

Review: The day the protected period ends, May 24, 1998, the worker reviews Mr. Apple's resource eligibility and finds that Mr. Apple has not transferred all of the resources out of his name. His resources as of May 25, 1998 total \$15,000. The protected period of eligibility was over on May 24, so the CSRA is no longer subtracted from his resources. Because his resources exceed the \$2,000 resource limit, his Medicaid is canceled effective June 30, 1998 (cannot cancel on May 31 because of 10-day advance notice period requirement).

Re-application: Mr. A reapplies for Medicaid on August 9, 1998 and requests retroactive coverage for July 1998. He is still institutionalized. Because he had previously established Medicaid eligibility as an institutionalized spouse, only **his** resources are considered in determining his eligibility. His resources on July 1, 1998 and throughout August 1998 were \$3,000. Because \$3,000 exceeds the resource limit, he is not eligible retroactively for July 1998 and he is not eligible in August 1998 because his resources did not go below the limit in August. Because he already had a protected period of eligibility based on his previous Medicaid application, **the CSRA and protected period policy do not apply**. His August 1998 application is denied because of excess resources.

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

A. Entitlement After Spenddown Met When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

B. Procedures

1. Coverage Dates Coverage begin date is the first day of the month; the coverage end date is the last day of the month.

2. Program Designation **a. If the institutionalized spouse does NOT have Medicare Part A:**

- Aged = 18
- Blind = 38
- Disabled = 58
- Child Under 21 in ICF/ICF-MR = 98
- Child Under Age 18 = 88
- Juvenile Justice Child = 85
- Foster Care/Adoption Assistance Child = 86
- Pregnant Woman = 97

b. If the institutionalized spouse has Medicare Part A:

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

1) When income is less than or equal to the QMB limit, enroll using the following PDs:

- Aged = 28
- Blind = 48
- Disabled = 68

2) When income is greater than the QMB limit, enroll using the following PDs:

- Aged = 18
- Blind = 38
- Disabled = 58

3. Patient Pay Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

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

M1480.400 PATIENT PAY

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

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

<i>\$1,561.25</i>	<i>7-1-04</i>	
<i>\$1,515.00</i>	<i>7-1-03</i>	
- C. Monthly Maintenance Needs Allowance Maximum**

<i>\$2,319</i>	<i>1-1-04</i>	
<i>\$2,266.50</i>	<i>1-1-03</i>	
- D. Excess Shelter Standard**

<i>\$468.38</i>	<i>7-1-04</i>	
<i>\$454.50</i>	<i>7-1-03</i>	
- E. Utility Standard Deduction (Food Stamps Program)**

<i>\$206</i>	<i>1 - 3 household members</i>	<i>10-1-03</i>
<i>\$253</i>	<i>4 or more household members</i>	<i>10-1-03</i>
<i>\$194</i>	<i>1 - 3 household members</i>	<i>10-1-02</i>
<i>\$240</i>	<i>4 or more household members</i>	<i>10-1-02</i>

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).

- newly eligible Medallion II enrollees who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their MCO enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. The enrollee, MCO, or obstetrical provider can make exclusion requests. Following end of pregnancy, these individuals shall be required to enroll in Medallion II to the extent they remain eligible for full Medicaid benefits.
- recipients who have been pre-assigned to the MCO but have not yet been enrolled, who have been diagnosed with a terminal condition, and whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.
- recipients who are inpatients in hospitals, other than those listed above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge.
- Certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) and who meet DMAS review.

**1. Foster Care/
Adoption
Assistance
Children**

All Foster Care and Adoption Assistance children enrolled in MMIS with a Program Designation (PD) of 74, 76, or 86 are automatically excluded from participating in managed care. Foster Care/Adoption Assistance children who are enrolled under any other PD can be exempted from Medicaid managed care programs. If a worker finds that a Foster Care/Adoption Assistance child is enrolled in a managed care program, the worker may request that the child be removed from managed care and placed in fee-for-service Medicaid through the following process:

- Complete the Foster Care Child-Exemption from Managed Care form (see Appendix 1 to this chapter). The custody order, *emergency removal order, or a statement on agency letterhead signed by the director or foster care supervisor verifying the child is in the agency's custody and the date the agency received custody* must be attached to the form in order to have the child exempted from managed care.
- Fax the form to (804) 786-5799.

Exemption requests may take up to 5 business days to complete. Disenrollment is effective at the end of the month of notification (not retroactively). The LDSS can verify disenrollments by *checking the MMIS Managed Care Assignment screen for a managed care end date*.

2. Other Exempt Recipients

Recipients other than Foster Care/Adoption Assistance children not enrolled in PD 74, 76, or 86 who are exempt from enrollment in managed care are excluded based on information supplied to MMIS at the time of enrollment.

C. Choice of Managed Care Programs/PCPs

Recipients who are required to participate in a managed care program will be notified within 15 - 45 days of enrollment in Medicaid and asked to choose either a MEDALLION PCP or one of the Medallion II MCOs operating in the recipient's geographical region. A list of MCOs operating in each region can be obtained online at www.dmas.state.va.us or by contacting the Managed Care Helpline at 1-800-643-2273 to request a comparison chart.

D. Good Cause

MEDALLION

The MEDALLION program has an annual open enrollment period of 90 days that applies to individuals in MEDALLION only areas. During the open enrollment period, MEDALLION enrollees may change Primary Care Physicians (PCPs). If an enrollee wishes to change his PCP outside of the open enrollment period, he must make a good cause request to DMAS.

Medallion II

In the Medallion II program, good cause consists of a pre-defined set of operational conditions that allows an enrollee to change from one Managed Care Organization (MCO) to another. In areas where there is only one MCO, an enrollee may change from either MEDALLION or the MCO to the other program. The good cause provision applies only after the initial 90-day enrollment period has ended.

If a good cause reason exists, the enrollee must write a letter to the DMAS Managed Care Division providing supporting documentation. All written correspondence should be directed to the following address and/or fax number:

The Department of Medical Assistance Services
Managed Care Division
600 East Broad Street
11th Floor
Richmond, VA 23219
(fax) 804-786-5799

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 1-886-386-8331.

Recipients Enrolled in Managed Care

Recipients enrolled in managed care should be referred to the Managed Care Helpline at 1-800-643-2273. 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 1-886-386-8331. Medallion II enrollees who need assistance with transportation must contact their MCO directly.

B. Copayments

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. Individuals
Exempt from
Copayments**

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,
- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and
- individuals receiving *Medicaid community-based care (CBC) waiver services and hospice care*.

**C. Services with No
Copayments**

The following services do not have copayments:

- emergency-room services,
- pregnancy-related services,
- family planning services, and
- dialysis services.

D. Covered Services

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- clinical psychologist services;
- community mental retardation services, including day health rehabilitation services and case management;
- dental services for individuals under age 21 years;
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services, including personal care, adult day health care, respite care, private duty nursing, case management, mental retardation services, and services for the developmentally disabled;
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;
- hospice services;

FOSTER CARE CHILD
EXEMPTION FROM MEDICAID MANAGED CARE PROGRAMS
(MEDALLION and Medallion II)

A copy of the Custody Order or Removal Order must be attached to this form in order for the disenrollment to be processed. In the event the Custody Order or Removal Order is not available, a statement on agency letterhead signed by the director or a foster care supervisor verifying the child is in the custody of the agency and the date the agency received custody must be included with this form.

In order for exemptions to occur in a timely manner, please fax this form to Tabitha Taylor at 1-804-786-5799.

Medicaid Enrollee ID# _____

Name _____

Address _____

Date _____

City/County Code _____

Case Worker _____

Medicaid Enrollee ID# _____

Name _____

Address _____

Date _____

City/County Code _____

Case Worker _____

Disenrollment is not retroactive. Disenrollment can be confirmed by checking the VaMMIS Managed Care Assignment screen for a managed care end date.

FAMIS ALIEN ELIGIBILITY CHART

QUALIFIED ALIEN GROUPS	ARRIVED BEFORE AUGUST 22, 1996	ARRIVED ON OR AFTER AUGUST 22, 1996	
		1 ST 5 YEARS	AFTER 5 YEARS
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	Eligible	Eligible	Eligible
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	Eligible	NOT Eligible	Eligible
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	Eligible	NOT Eligible	Eligible
Aliens, <i>other than Cuban or Haitian Entrants</i> , paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	Eligible	NOT Eligible	Eligible
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	Eligible	NOT Eligible	Eligible
ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE			
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)	Eligible		
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)} I-551; I-94; I-688B	Eligible		
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge's Order	Eligible		
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]	Eligible		

UNQUALIFIED ALIEN GROUPS
<u>NOT</u> ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)
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)
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)
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)
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))
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)
Aliens residing in the U.S. under orders of supervision (I-220B)
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)
Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the INS does not contemplate enforcing (Immigration Judge Court Order)
Any other aliens living in the US with the knowledge and permission of the INS whose departure the agency does not contemplate enforcing (INS Contact)
Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired
Visitors (non-immigrants): tourists, diplomats, foreign students, temporary workers, etc. (I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-1186; SW-434; I-95A)