



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

October 28, 2004

MEDICAID ELIGIBILITY MANUAL – VOLUME XIII

TRANSMITTAL #78

The following acronyms are used in this transmittal:

- CDPAS – Consumer Directed Personal Attendant Services
- DDS – Disability Determination Services
- FAMIS – Family Access to Medical Insurance Security Plan
- LTC – Long-term Care
- MN – Medically Needy
- US – United States
- USCIS – United States Citizenship and Immigration Services

This transmittal contains several updates, which are already in effect. The new Food Stamp Utility Standard Deduction, effective October 1, 2004 is used to determine the Community Spouse's income allowance. The list of Local Choice agencies used for FAMIS eligibility determinations has also been updated, effective July 1, 2004.

As a result of legislation passed during the 2004 session of the General Assembly, the DDS referral process has been expanded to include expedited referrals for hospitalized patients needing placement in a rehabilitation facility. This revised policy was in Broadcast 2816 (September 3, 2004).

Other significant policy changes in this transmittal include the implementation of an *ex parte* annual renewal (redetermination) process for Medicaid eligibility. Whenever possible, the eligibility worker will use information available to the agency and renew eligibility without contact with the recipient. No signed renewal form is needed when an *ex parte* renewal is completed. When resource or other necessary information must be obtained from the recipient, a new one-page renewal form will be used.

The policy on the treatment of the subsequent receipt of compensation for a transferred asset has been significantly modified. The return of all transferred assets or the receipt of adequate compensation for a transferred asset voids the penalty period, and the eligibility worker must complete a re-evaluation of the asset transfer and Medicaid eligibility back to the beginning of the penalty period. The receipt of partial compensation requires the transfer to be re-evaluated and the penalty period to be recalculated.

Two clarifications regarding policy on pregnant woman and newborns are included in this transmittal. First, children born to women certified to receive emergency services payment of labor and delivery are eligible for Medicaid in the Child Under 1 Year ("Certain Newborns") covered group as long as they live with the mother. No application is required for the newborn and enrollment can be completed when the agency certifies the labor and delivery. This clarification was in Broadcast 2865 (October 20, 2004). Also, changes in the income of a pregnant woman do not affect her eligibility as long as she was retroactively eligible (i.e. when the child was born) and had a Medicaid-covered service on the child's date of birth. There is no distinction made regarding whether the woman applied before or after the pregnancy ended.

Additional clarifications to policy in this transmittal include: acceptability of photocopied alien status verification documents; documentation that can be used to verify continuous presence; verification not required for excluded unearned income; exclusion of all educational scholarships and grants as income; definition of an annuity for Medicaid purposes and the process for determining if an annuity is a countable resource; and that Medicare is no longer considered creditable health insurance coverage for FAMIS eligibility purposes.

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

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0120 Table of Contents Pages 7-10 Appendix 3a	Subchapter M0120 Table of Contents Pages 7-10	Appendix 3a (FAMIS Supplemental Application Form, #032-03-365) was removed from the Table of Contents. On page 7, clarified that a child born to an emergency services alien is deemed eligible for Medicaid. On page 8, removed the FAMIS Supplemental Application Form from the list of prescribed Medicaid applications. Page 9 is a runover page. Page 10 is a reprint. Appendix 3a is deleted.
Subchapter M0220 Pages 3-6 Pages 21-22 Appendix 3, page 1	Subchapter M0220 Pages 3-6a Pages 21-22 Appendix 3, pages 1-2	On page 3, clarified that photocopies of documents showing immigration status are acceptable. On pages 4 and 5, updated references to USCIS. On pages 6 and 6a, clarified acceptable documentation for proof of continuous presence when the USCIS is not able to provide it. Page 21 is a runover page. On page 22, clarified that newborns of emergency services aliens are eligible for Medicaid as certain newborns. Appendix 3, page 1 is a reprint. Appendix 3, page 2 was inadvertently removed from the previous transmittal and has been restored.
Subchapter M0310 Table of Contents Pages 21-26 Appendix 4	Subchapter M0310 Table of Contents Pages 21-26 Appendix 4 Appendix 5	Appendix 5 (Sample Cover Sheet for Expedited Referral to DDS) was added to the Table of Contents. Pages 21 and 22 are runover pages. On pages 23-26, added policy on the expedited disability determination process.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0320 Pages 45-48	Subchapter M0320 Pages 45-48	Appendix 4 (DDS Referral Form) was revised to include the expedited referral request. Appendix 5 was added. Page 45 is a reprint. On page 46, clarified that a child born to a woman eligible for Medicaid payment of labor and delivery as an emergency services alien meets the definition of a certain newborn. On pages 47 and 48, clarified that changes in the income of a pregnant woman do not affect her eligibility as long as she is retroactively eligible and had a Medicaid-covered service on the child's date of birth. On page 48, also clarified that a Medicaid application is not required for a certain newborn.
Subchapter M0330 Pages 17-20	Subchapter M0330 Pages 17-20	On page 17, clarified that the spenddown liability must be recalculated when the MN pregnant woman's income changes prior to establishing eligibility. On page 18, revised the example. Page 19 is a runover page. On page 20, clarified that a child born to a MN woman eligible for Medicaid payment of labor and delivery as an emergency services alien meets the definition of a certain newborn.
Subchapter M0730 Pages 1, 2 Pages 7, 8	Subchapter M0730 Pages 1, 2 Pages 7, 8	On page 1, clarified that verification of excluded unearned income is not required. On page 2, clarified that all educational grants and scholarships are excluded as income. On page 7, updated the reference to Worker's Compensation and clarified that the amount of unemployment compensation counted is the gross benefit before any taxes or deductions. Page 8 is a reprint.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter S0830 Pages 15, 16	Subchapter S0830 Pages 15, 16	Page 15 is a reprint. On page 16, clarified the definition of an annuity for Medicaid purposes.
Subchapter S1140 Table of Contents Pages 23-26	Subchapter S1140 Table of Contents Pages 23-26a	Added section M1140.260 (Annuities) to the Table of Contents. Page 23 is a reprint. On pages 24 and 25, expanded the introduction and clarified the treatment of US Savings Bonds. On pages 26, added section M1140.260, clarifying the treatment of annuities as a resource. Page 26a is a runover page.
Subchapter M1420 Appendix 4	Subchapter M1420 Appendix 4	Appendix 4 (CDPAS Waiver Criteria Review Form) was revised. The form authorizes the local agency to evaluate the applicant as an institutionalized individual.
Subchapter M1450 Pages 19, 20 Pages 35, 36	Subchapter M1450 Pages 19, 20 Pages 35, 36	Page 19 is a reprint. On page 20, clarified the definition of an annuity for Medicaid purposes. Page 35 is a reprint. On page 36, revised policy on the treatment of a subsequent receipt of compensation for a transferred asset.
Subchapter M1480 Pages 17, 18 Pages 65, 66	Subchapter M1480 Pages 17, 18 Pages 65, 66	Page 17 is a reprint. On page 18, updated the spousal resource standards. Page 65 is a reprint. On page 66, updated the LTC Food Stamp Utility Standard Deduction, effective October 1, 2004.
Subchapter M1520 Table of Contents Pages 1-10 Pages 23, 24	Subchapter M1520 Table of Contents Pages 1-10 Pages 23, 24 Appendix 2	Added Appendix 2 (Medicaid Renewal, form 032-03-669) to the Table of Contents. On pages 1-8, significantly revised policy on the annual complete review (renewal) of Medicaid eligibility, including the special renewal requirements for certain covered groups. Page 9 is a runover page. Page 10 is a reprint. On pages 23 and 24,

Remove and Destroy Pages

Insert Attached Pages

Significant Changes

Subchapter M1640
Pages 5, 6

Subchapter M1640
Pages 5, 6

clarified the responsibilities of local agencies when a case is transferred. Appendix 2 was added.

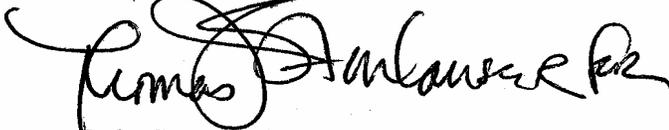
Page 5 is a reprint. On page 6, clarified policy on the responsibilities of local agencies regarding interaction with the DMAS Hearing Officer

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Appendix 5

Chapter M21
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Appendix 7

Appendix 5 (FAMIS Supplemental Application Form, #032-03-365) was deleted from the Table of Contents. Page 3 is a reprint. On page 4, Medicare was deleted from the list of creditable health plans. On Page 5, the references to TRICARE and Anthem were updated. Page 6 is a reprint. On page 7, the example was revised for accuracy. On page 8, deleted the reference to the FAMIS Supplemental Application Form. Appendix 2 (Local Choice Agencies) was updated, effective July 1, 2004. Appendix 5 was deleted. Appendix 7, page 1 is a reprint. Appendix 7, page 2 was inadvertently removed from the previous transmittal and has been restored.

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



Duke Storen, Director
Division of Benefit Programs

Attachments

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2. If the above conditions are met, an application may be made by any of the following:
 - his guardian or conservator,
 - attorney in fact,
 - executor or administrator of his estate,
 - his surviving spouse, or
 - his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

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

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

E. Unsigned Application

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

F. Invalid Signature

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

M0120.300 Medicaid Application Forms

A. General Principle

A signed application is required for all initial requests for medical assistance. The Request for Assistance---ADAPT---, form #032-03-875 (see M0120, Appendix 2) may be used to establish and preserve the application date, but a signed application must be submitted in order for eligibility to be determined.

A child born to a mother who was Medicaid eligible at the time of the child's birth, *including a child born to an emergency services alien certified for Medicaid payment for labor and delivery*, is deemed to have applied and been found eligible for Medicaid on the date of the child's birth. An application for the child is not required. The child remains eligible for Medicaid to age 1 year so long as the mother remains eligible for Medicaid, or would be eligible if she were *still* pregnant, and they live together.

**B. Medicaid
Application Forms**

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

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

Appendices 3 through 8 of this chapter contain sample prescribed Medicaid application forms. Other forms that serve as Medicaid application forms are listed in section M0120.300.D.

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

- Application for Benefits, form #032-03-824, also referred to as the Combined application, may be used by any applicant (see M0120, Appendix 3).
- Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (see M0120, Appendix 4);
- Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (see M0120, Appendix 5);
- Application for Children's Health Insurance in Virginia, form #FAMIS-1 (see M0120, Appendix 6);
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application/Redetermination, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. This form is not to be given to applicants by the local departments of social services (M0120, Appendix 7 is provided for reference purposes);
- Signed ADAPT Statement of Facts (*SOF*). *If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant and attached to the SOF.*
- 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.

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.

3. Verification

For an individual born outside the U.S. other than an adopted child, citizenship is verified by a certificate of derivative citizenship, passport, naturalization papers, or document issued by a U.S. Embassy or Consulate attesting that the person is a U.S. citizen born abroad, such as Form FS-240, "Report of Birth Abroad of a Citizen of the U.S." or Form I-97 "Consulate Report of Birth or Certification of Birth." If such documents are not available, citizenship must be verified through the nearest U.S. *Citizenship and Immigration Services (USCIS)*, formerly known as Immigration and Naturalization Service (INS). Locations and telephone numbers are:

Norfolk Commerce Park
5280 Henneman Drive
Norfolk, Virginia 23513
Telephone - (757) 858-6183

4420 N. Fairfax Drive
Arlington, Virginia 22203
Telephone - (703) 235-4026

For a legally adopted child born outside the U.S., citizenship is verified by the adoption papers and verification of lawful permanent resident status at the time of adoption.

M0220.200 ALIEN IMMIGRATION STATUS**A. Introduction**

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

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.700 to enroll an eligible emergency services alien in Medicaid for emergency services only.

M0220.201 IMMIGRATION STATUS VERIFICATION**A. Verification Procedures**

An alien's immigration status is verified by the official document issued by the *USCIS* and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. The EW must see the original document *or a photocopy*. *Submission of just an alien number is NOT sufficient verification.*

If the alien

- has an alien number but no *USCIS* document, or
- has no alien number and no *USCIS* document,

use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

B. Documents That Verify Status

Verify lawful permanent resident status by an Alien Registration Receipt Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on form I-94.

Verify lawful admission by an Alien Registration Receipt Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).

Form I-151, Form AR-3 and AR-3a are earlier versions of the Alien Registration Receipt Card. An alien with one of the older cards who does not have an I-551 should be referred to *USCIS* to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-755-0777.

C. Letters that Verify Status

The *USCIS* and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with *USCIS* forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For *USCIS* letters, contact the local *USCIS* office for assistance in identifying the alien's status (see Appendix 1 of this subchapter). For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 5 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

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

E. Expired or Absent Documentation

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

If the applicant provides an alien registration number with supporting verification of his or her identity, use the SAVE procedures in M0220.202 below to verify immigration status. If an applicant presents an expired I-551, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551, follow procedures for initiating a secondary verification.

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

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

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

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

1. Primary Verification

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

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

SAVE is accessible either by the local agency directly or through regional office contact. A primary verification document must be **initiated prior to case approval**.

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

The primary verification document must be filed in the case record.

2. Secondary Verification

Secondary verification is required in the following situations:

- a. The alien has an alien number but no *USCIS* document, or the alien has no alien number and no *USCIS* document.
- b. Primary verification generates the message "Institute Secondary Verification" or "No File Found."
- c. Discrepancies are revealed when comparing primary verification to the original immigration document.
- d. Immigration documents have no Alien Registration Number (A-Number).

- e. Documents contain an A-Number in the A60 000 000 or A80 000 000 series.
- f. The document presented is an *USCIS* Fee Receipt.
- g. The document presented is Form I-181 or I-94 in a foreign passport that is endorsed "Processed for I-551, Temporary Evidence of Lawful Permanent Residence," and the I-181 or I-94 is more than one year old.

When secondary verification is required, the agency will complete the top portion of a Document Verification Request (Form G-845). Appendix 2 of this subchapter contains a copy of the form.

**B. Document
Verification
Request (Form
G-845)**

If the alien has filed an *USCIS* application for or received a change in status, the application for or change in status in itself is not sufficient basis for determining immigration status. Likewise, any document which raises a question of whether *USCIS* contemplates enforcing departure is not sufficient basis for determining the alien's status. In such situations, verify the alien's status with *USCIS* using the Document Verification Request (Form G-845). For an alien who entered the U.S. before 8-22-96 and whose status is adjusted to a qualified status after he entered the U.S. use the Form G-845 Supplement to request the period of continuous presence in the U.S. A copy of the G-845 Supplement (S) is in Appendix 2a of this subchapter.

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

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

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. *A photocopy of the completed G-845 form must be filed in the record as evidence that the form has been forwarded to USCIS.* Refer to Appendix 1 for the *USCIS* mailing address appropriate to your local DSS agency.

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

Acceptable documentation includes:

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

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

C. Agency Action

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

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

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

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

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

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

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

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

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

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

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

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

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

The verification must be documented in the record.

NOTE: A child born to a woman certified for Medicaid payment for the labor and delivery is entitled to Medicaid as a newborn child (see M320.301) or as a Child Under Age 1 (M330.302) without having to file an application as long as the child continues to live with the mother.

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

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

The worker must send the medical evidence to:

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

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

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

Line Item	MEDICAID ALIEN CODE CHART <i>QUALIFIED ALIEN GROUPS</i>	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

	UNQUALIFIED ALIEN GROUPS	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>

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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.

An applicant who received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason other than no longer meeting the disability or blindness requirement continues to meet the disability or blindness definition.

An applicant who has not received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application must reapply for a disability determination.

1. Individual Has Been Determined Disabled and receives Benefits From SSA

If an applicant alleges that he has been found to be disabled and is receiving SS/SSI disability benefits, verify his disability status through a SVES (*State Verification Exchange System*) request or through documentation provided to the applicant by the SSA.

If the individual applies for retroactive coverage and the SSI decision or the SVES SSI information do not specify a disability onset date that covers the Medicaid application's retroactive period, refer the individual to DDS for a disability determination using the procedures in E. 1. below.

2. Individual Has Been Determined Totally Disabled by RRB

If an applicant alleges that he has been found to be totally disabled and is receiving RR benefits, verify his disability by contacting the RRB at 804-771-2997 or 1-800-808-0772, or through documentation provided to the applicant by the RRB.

3. Individual Has Been Determined Disabled by DDS

If the applicant alleges that he has been found to be disabled by the DDS but there is no disability determination on file, verify his status by contacting the DDS at 804-662-9222.

D. DDS Disability Determinations- General Information

An individual who is claiming a disabling condition and does not receive SS/SSI disability benefits, or RR total disability benefits and has not been denied disability or has not had disability determined by DDS, must have his disability determined by DDS.

The DDS makes a determination of disability when the:

- applicant alleges a disabling condition and has never applied for a disability from SSA or has not been denied disability within the past 12 months;
- SSA has not made a decision on a pending SS/SSI claim; or
- applicant alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

1. Hospital Referrals to DDS for Expedited Disability Determination

The 2004 Budget Bill mandated DDS make a disability determination within 7 working days of receipt of a referral from DSS when the Medicaid applicant is hospitalized and needs to be transitioned to a rehabilitation facility. To identify those hospitalized individuals who require an expedited disability determination, the following procedures have been established:

a. Hospital staff will:

- *send DSS the Medicaid application and a cover sheet (see Appendix 5 for an example of the cover sheet); and simultaneously*
- *send DDS the medical documentation (disability report, authorizations to release information and medical records) needed to make the disability determination and a copy of the cover sheet.*

b. DDS must:

- *make a disability determination within 7 working days; and*
- *fax the result of the disability decision to the DSS.*

c. DSS must:

- *fax a completed DDS Referral Form (see Appendix 5 to this subchapter) to DDS at (804) 662-9366, verifying receipt of the Medicaid application;*
- *give priority to processing the applications and immediately request any verifications needed;*
- *process the application as soon as the DDS disability determination and all necessary verifications are received; and*
- *notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.*

Should DDS be unable to render a decision within 7 working days, DDS will send a communication to the DSS advising that the disability determination has been delayed.

2. DSS Referral to DDS Required When Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the DSS to process the application within 90 days, provided all medical information has been submitted. Follow the procedure in E. 1. below for making a referral to DDS *except when a hospital has initiated an expedited disability determination (see D.1. above).*

3. DSS Referral to DDS Required When SSA Denied Disability Within Past 12 Months

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

- a. The applicant alleges a condition that is new or in addition to the condition(s) already considered by SSA,

OR

- b. The applicant alleges his condition has changed or deteriorated causing a new period of disability, AND
- he no longer meets the SSI financial requirements but might meet Medicaid financial requirements, or
 - he applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

If the conditions in a. or b. exist, DDS must make a disability determination. The eligibility worker must follow the procedure in E. 1. below to make a referral to DDS. Information regarding the new, changed and/or deteriorated condition(s) must be identified and sent to DDS using the procedure in E. 1. below.

If the conditions in a. or b. do not exist, the SSA denial of disability is final for Medicaid purposes. Do not make a referral to DDS for a disability determination.

4. Referral to DDS When SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, the eligibility worker must follow the procedure in E. 1. below to make a referral to DDS.

**E. DSS Procedures
When a Disability
Determination is
Required**

**1. DSS Referrals
to DDS**

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

- [Disability Report Adult SSA-3368-BK](#) (see Appendix 1 to this subchapter) or the [Disability Report Child SSA-3820-BK](#), (see Appendix 2 to this subchapter) and
- *a minimum of 5 signed, original forms:* [Authorization to Disclose Information to the Social Security Administration form SSA-827-02-2003](#) (see Appendix 3 to this subchapter) **or** 1 for each medical provider if more than 5; and
- a DDS Referral Form - 032-03-095/05 (see Appendix 4 to this subchapter).

When the SSA disability report and the Authorization to Disclose Information to the Social Security Administration forms must be sent to the applicant for completion, send the request immediately, giving the applicant 10 days to return the completed forms. When the completed forms are returned, mail them along with the DDS Referral form to:

Disability Determination Services Unit
5211 West Broad Street, Suite 201
Richmond, Virginia 23230-3032

Do not send referrals to DDS via the courier.

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

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

**2. Application for
Other Benefits**

Individuals with a work history, or individuals whose disability began prior to reaching age 22 years and whose parent(s) is retired (because of age or disability) or deceased must apply for Social Security or RR benefits as a disabled individual as a nonfinancial requirement of Medicaid eligibility. Refer individuals with a work history to the appropriate SSA Office to apply for benefits. Refer individuals who report a railroad work history to the Railroad Retirement Board (RRB) to apply for benefits. Applicants are not required to apply for SSI benefits.

Do not delay processing the Medicaid application while waiting for the applicant to apply for SSA/RR benefits. However, if the applicant does not apply for SSA/RR benefits within 45 days from the date of the Medicaid application, deny the Medicaid application due to “failure to

apply for benefits (SSA/RR) for which the individual might be entitled” (see M0270). Notify the DDS to stop action on the disability determination.

**F. Communication
Between Agency
and DDS**

**1. Eligibility
Worker
Responsibilities**

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

If the eligibility worker is aware of changes in the applicant’s situation that would make him ineligible for Medicaid even with a favorable disability determination, the information must immediately be provided to the DDS so that office will not complete a disability determination. When an application is denied for a nonfinancial reason not related to the disability determination, DDS must be notified immediately.

**2. DDS
Responsibilities**

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

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

**G. Notice to the
Applicant**

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

**H. Applicant is
Deceased**

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

**I. Subsequent SSA or
RRB Disability
Decisions**

When SSA or the RRB make a disability decision subsequent to the DDS decision which differs from the DDS decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in D. 3. above applies.

a. SSA/RRB Approval

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM

DISABILITY DETERMINATION SERVICES (DDS) REFERRAL FORM

TO: **DISABILITY DETERMINATION SERVICES UNIT**
5211 West Broad Street, Suite 201
Richmond, Virginia 23230-3032

RESERVED FOR DDS USE

Please print or type

A. APPLICANT INFORMATION

SSN: _____ CASE #: _____

NAME: _____ BIRTH DATE: _____

MAILING ADDRESS: _____

MEDICAID APPLICATION DATE: _____ SSA/SSI APPLICATION DATE: _____

IF DECEASED, DATE OF DEATH: _____ DEATH CERTIFICATE ATTACHED. YES () NO ()

B. REQUEST TO DDS FOR DISABILITY DETERMIANTION:

_____ **EXPEDITED REFERRAL.** HOSPITALIZED PATIENT REQUIRES PLACEMENT IN A REHABILITATION FACILITY AND HOSPITAL SENT DISABILITY REPORT AND RELEASE FORMS TO DDS ON _____. FAX THIS REFERRAL TO (804)-662-9366.

_____ DETERMINE DISABILITY. DISIBILITY REPORT AND RELEASE FORM(S) MUST BE ATTACHED.

_____ DETERMINE DISABILITY. SSA/SSI DENIED DISABILITY IN PAST 12 MONTHS. DISABILITY REPORT AND RELEASE FORM(S) MUST BE ATTACHED. Evaluation by DSS shows the following exception applies:

_____ Applicant alleges a new condition that has not been considered by DDS/SSA;

_____ Applicant alleges his condition has changed or deteriorated AND

- he no longer meets SSI financial requirements, but might meet Medicaid financial requirements; OR
- he has applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

_____ DETERMINE ONSET DATE OF DISABILITY. RETROACTIVE COVERAGE FOR: _____ REQUESTED. REPORT AND RELEASE FORM(S) MUST BE ATTACHED. PERIOD

Worker's Name Printed: _____ Worker Number: _____ FIPS Code: _____

Agency Name: _____ Phone # (____) _____

Agency Address: _____ FAX #: (____) _____

_____ Date Mailed: _____

NOTE: This referral is not valid unless it is submitted by the Department of Social Services. If the applicant, another individual, or another agency completes this form, it should be sent to the local Department of Social Services. DDS cannot process forms that are incomplete or that do not have appropriate DSS identification and coding.

SAMPLE
Cover Sheet for Expedited Referral to DDS and DSS

This cover sheet is used when a Medicaid Disability Determination is required to transition a hospitalized patient to a rehabilitation facility.

Patient: _____ **SSN:** _____

This individual appears to satisfy the severity and duration requirements contained in Section 223(d) and Section 1614(a) of the Social Security Act.

DISABILITY is defined as:

The inability to do any substantial gainful work, because of a severe, medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.

The Medicaid Application has been sent to this Dept. of Social Services:

Agency Name: _____

Agency Address: _____

Date Mailed: _____

The information checked below is being faxed/overnighted to:

**Dept. of Disability Determination Services, Medicaid Unit
5211 West Broad Street, Suite 201
Richmond, VA 23230-3032
Telephone – 1-800-578-3672, Fax – 1-804-662-9366**

_____ **Form SSA-3368 Disability Report Form**

_____ **SSA-827 Authorization to Disclose Information**

_____ **Medical Reports**

_____ **Medical History & Physical, including consultations**

_____ **Clinical findings (such as physical/mental status examination findings)**

_____ **Laboratory findings (such as latest x-rays, scans, pathology reports.)**

_____ **Diagnosis.**

_____ **A physician’s statement providing an opinion about the individual’s expected response to treatment and prognosis of residual capacity one year from onset.**

Specific Clinical and Laboratory Findings Generally Required to Support Diagnosis and Assess Impairment Severity:

- medically acceptable imaging - X-rays/scans/MRIs
- spirometry, DLCO (diffusing capacity of lungs for carbon monoxide), AGBS (arterial blood gas studies)
- EKGs, cardiac catheterization, echocardiogram, Doppler studies
- pathology reports
- psychological test reports

Name of Hospital: _____

Date Completed: _____

Hospital Contact Person: _____

Telephone: (____) _____

Please Print

Fax: (____) _____

C. Financial Eligibility

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

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

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

D. Entitlement

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

E. Enrollment

The program designations are:

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

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

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

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

B. Procedure

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

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

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

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

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

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

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

2. Newborn Child

42 CFR 435.117 - A child born to a *woman* who was eligible for Medicaid (*including Medicaid payment for labor and delivery as an emergency services alien*) at the time the child was born is eligible as a newborn child under age 1 year. The child remains eligible for Medicaid as long as the mother remains eligible for Medicaid or would be eligible if she were still pregnant, and they live together.

a. Eligible To Age 1

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1 as long as the following conditions are met:

- 1) the child remains in the home with the mother, and
- 2) the child's mother remains eligible for Medicaid or the child's mother would be eligible for Medicaid if she were *still* pregnant.

b. Living With Mother

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

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

c. No Other Nonfinancial Eligibility Requirements

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

C. Financial Eligibility

1. Assistance Unit

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

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

2. Asset Transfer

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

3. Resources

There is no resource limit.

4. Income

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

5. Income Changes After Eligibility Established

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

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

6. Income Exceeds MI Limit

Spenddown does not apply to the medically indigent. If the applicant's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses.

Eligibility as medically needy must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

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

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

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

After her eligibility is established as a medically indigent pregnant woman, the woman's Medicaid entitlement continues through her

3. Resources

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

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

a. Resources Within The Limit

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

b. Resources Exceed The Limit

If current resources exceed the limit, she is not eligible in this covered group.

4. Income

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

**5. Income Exceeds
MN Limit**

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

**6. Income
Changes**

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

The spenddown liability must be recalculated when an income change is reported prior to eligibility being established.

C. Entitlement

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

EXAMPLE:

A pregnant woman living in Group III applied for Medicaid on March 3. Her estimated date of conception is January 24, and her due date is October 20. Her income exceeds the MI limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period March 1 through August 31. She meets the spenddown on May 11 and is enrolled in Medicaid as a medically needy pregnant woman through August 31.

She reapplies for Medicaid on September 5. Her income increased in August. Because her income increased after she established eligibility, but before the date her pregnancy ended, the increase in income does not affect her Medicaid eligibility. Her income that was verified in March is used to calculate her spenddown. She is placed on spenddown for the period September 1 through February 28, using the same spenddown amount from her previous spenddown and she establishes eligibility. Her child is born on October 10. Her Medicaid coverage as a pregnant woman is canceled effective December 31, the last day of the month in which the 60th day occurred after her pregnancy ended. She no longer meets the pregnant woman covered group requirements.

Note: The eligibility worker must evaluate the individual's eligibility in all other covered groups prior to taking action to cancel the coverage.

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN), program designation "97."

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M0330.302 NEWBORN CHILDREN UNDER AGE 1**A. Policy**

42 CFR 435.301 (b)(1)(iii) - If the state chooses to cover the MN, the State Plan must provide MN coverage to all newborn children born on or after October 1, 1984 to a woman who is eligible as MN and is receiving Medicaid on the date of the child's birth. *Coverage must be provided to those newborn children whose mothers were eligible as MN but whose coverage was restricted to Medicaid payment for labor and delivery as an emergency service.* The child remains eligible for one year so long as the child is a member of the mother's household and the mother

- remains eligible in any Medicaid covered group, or
- would be eligible for Medicaid if she were pregnant.

The mother is considered to remain eligible if she meets the spenddown requirements in any consecutive spenddown budget period following the birth of the child.

B. Nonfinancial Eligibility

A child who meets this covered group:

- is under age of 1 year;
- was born to a mother who is found eligible for Medicaid as medically needy or meets spenddown effective on or before the date of the child's birth; and
- lives with his/her mother.

1. Continued Eligibility When Mother Becomes Ineligible

Any child born to an eligible pregnant woman will continue to be eligible in this covered group **up to age 1** even though his/her mother loses her eligibility, as long as the following conditions are met:

- the child remains in the home with the mother, and
- the mother would be eligible for Medicaid as medically needy if she were still pregnant.

EXAMPLE #4: A pregnant woman living in Group III applied for Medicaid on October 24, 1997. Her estimated date of conception is March 24, 1997, and her due date is December 20, 1997. Her income exceeds the MI limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period October 1, 1997 through March 31, 1998. She meets the spenddown on November 15, 1997, and is enrolled in Medicaid as MN effective November 15, 1997 through March 31, 1998.

Her child is born on November 30, 1997, and is enrolled in Medicaid as an MN newborn. The mother's Medicaid coverage is canceled effective January 31, 1998, the last day of the month in which the 60th day

GENERAL**M0730.001 INTRODUCTION TO UNEARNED INCOME**

- A. Policy - General** Unearned income is all income received by members of the family/budget unit that is not earned income. Unearned income consists of:
- benefits, including public assistance benefits received from another state
 - royalties
 - child/spousal support
 - dividends and interest
 - some rental income
 - gifts
 - some home energy assistance
 - contributions
 - lump sums
- B. Policy - When to Count Unearned Income** Unearned income is counted as income in the earliest month it is:
- received by the individual;
 - credited to the individual's account; or
 - set aside for the individual's use.
- C. Policy - What Amount of Unearned Income is Counted** The amount of unearned income received is counted as income.
- EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.
- D. Verifications** Verify the amount of the unearned income by an award letter or notice, a benefit payment check, or through contact with the source of the unearned income, *unless the source of the unearned income is listed in M0730.099 B. Verification of unearned income that is totally excluded is not required.*
- E. References**
- What is income, M0710.003
 - What is not income, M0715.050
 - When income is counted, M0710.030
 - How to estimate income, M0710.610

UNEARNED INCOME EXCLUSIONS - GENERAL**M0730.050 OVERVIEW OF EXCLUSIONS**

- A. Definitions** An exclusion is an amount of income that does not count in determining eligibility.

- B. Policy** Exclusions never reduce unearned income below zero. No unused unearned income exclusion may be applied to earned income.
- C. Procedure** First determine whether what is received is income. Next apply any appropriate exclusions of unearned income listed in this subchapter.
- D. Reference** What is not income, M0715.050

M0730.099 GUIDE TO EXCLUSIONS

- A. Introduction** The following provides a list of exclusions of unearned income:
- B. List of unearned income exclusions**
- 1. Home Produce** Home produce of the individual utilized for his/her family's own consumption is excluded.
 - 2. Food Stamps** *Benefits* under the Food Stamp Program *are* excluded.
 - 3. Commodities** The value of foods donated under the U.S.D.A. Commodity Distribution Program, including those furnished through school meal programs, is excluded.
 - 4. Federal Relocation Assistance** Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is excluded.
 - 5. Nutrition Program for the Elderly** Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended, are excluded.
 - 6. Grant or Loan Administered by U.S. Secretary of Education** Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the U.S. Secretary of Education is excluded. Programs that are administered by the U.S. Secretary of Education include: Pell Grant, Supplemental Educational Opportunity Grant, Perkins Loan, Guaranteed Student Loan, including the Virginia Educational Loan, PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.
 - 7. College Work Study Programs** Any funds derived from the federal College Work Study Program or any other college work study programs are excluded.
 - 8. Educational Scholarships and Grants** *All educational scholarships and grants are excluded.*

B. Definitions

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

C. List of *Benefits*

The following are examples of benefits:

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

D. Procedure

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

M0730.200 UNEMPLOYMENT COMPENSATION**A. Policy**

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

B. Procedures

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

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

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

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

B. TANF Recipients

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

The State, through the Division of Child Support Enforcement (DCSE), sends the first \$50 of support collected in a month on behalf of the TANF assistance unit to that unit. (If the total support collected is less than \$50, the entire amount is sent to the unit.) Any remaining amount of support is kept by the State as reimbursement of TANF payments made to the family. If DCSE collects more support than the State is entitled to keep as reimbursement for TANF paid, it will forward the excess to the TANF assistance unit. That excess amount is counted as unearned income.

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

C. Procedures

- 1. Retained by State** Child support collected by a State and retained as reimbursement for TANF payments is not income to a Medicaid recipient.
- 2. \$50 Pass Through** Child support collected by DCSE and paid to a TANF assistance unit as a \$50 (or less) pass-through of child support is not income to the Medicaid family/budget unit.
- 3. Amount in Excess of the \$50 Pass-Through** Child support collected by DCSE and forwarded to a TANF family because the support exceeds the amount which the State is entitled to keep as reimbursement for TANF is a payment of child support and is unearned income.
- 4. Direct Child/Spousal Support** Support collected by DCSE and paid to the Medicaid family/budget unit is unearned income in the form of child support to the family/budget unit. Support paid directly to the Medicaid family/budget unit by an absent parent or spouse is unearned income in the form of child/spousal support to the family/budget unit.

NOTE: The first \$50 of total child or child and spousal support paid to the family/budget unit is excluded. The \$50 exclusion is only applicable current child/spousal support payments received each month. The \$50 exclusion does not apply to alimony that is not commingled with child support.

- 5. Payments Made to Third Party (Other Than DCSE)** Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a rental agency in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid

S0830.115 GARNISHMENT OR OTHER WITHHOLDING

A. Policy

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

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

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

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

B. Kinds of Withholding

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

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

C. Procedure

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

D. Reference

Overpayment involved, S0830.110

BROAD CATEGORIES OF UNEARNED INCOME

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

A. Definitions

1. **Annuity** An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. *For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years. Payments received from an annuity are counted as unearned income.*
2. **Pensions and Retirement Benefits** Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.
3. **Disability Benefits** Disability benefits are payments made because of injury or other disability.

B. Policy

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

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

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

C. List of Payments

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

Black Lung Benefits.....	S0830.215
Foreign Payments.....	S0830.105
German Reparations Payments	S0830.710
Military Pensions	S0830.240
Office of Personnel Management (Civil Service and Federal Employment Retirement System) Payments.....	S0830.220
Railroad Retirement Payments.....	S0830.225
Title II Payments	S0830.210
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**3. Value--Stock
That Is Not
Publicly Traded**

a. **Traded**

The stock of some corporations is held within close groups and traded very infrequently. The sale of such stock is often handled privately and subject to restrictions. As a rule, it cannot be converted to cash within 20 working days.

b. **Evidence**

The burden of proof for establishing the value of this kind of stock is on the individual. The preferred evidence is a letter or other written statement from the firm's accountants giving their best estimate of the stock's value and the basis for the estimate, e.g.:

- most recent sale,
- most recent offer from outsiders,
- CMV of assets less debts on them,
- cessation of activity and sale of assets,
- bankruptcy, etc.

Keep the statement or a photocopy of it in the file.

S1140.230 MUTUAL FUND SHARES

A. Introduction

A mutual fund is a company whose primary business is buying and selling securities and other investments. Shares in a mutual fund represent ownership in the investments held by the fund.

**B. Development and
Documentation**

The development guidelines for stocks in S1140.220, apply to mutual funds shares. Many newspapers contain a separate table showing the values of funds not traded on an exchange.

S1140.240 U.S. SAVINGS BONDS

A. Introduction

U.S. Savings Bonds are obligations of the Federal Government. Unlike other government bonds, they are not transferable; they can only be sold back to the Federal Government. *U.S. Savings Bonds have a mandatory retention period:*

- *6 months for Series E, EE and I bonds issued prior to 2/1/03,*
- *12 months for Series EE and Series I bonds issued on or after 2/1/03, and*
- *6 months for Series H and HH bonds.*

U.S. Savings Bonds are resources the first month following the mandatory retention period.

NOTE: The mandatory retention period is the same for both paper and electronic Series EE and I bonds. Series E bonds have not been issued since June 1980.

B. Operating Policy

1. Sole Ownership

The individual in whose name a U.S. Savings Bond is registered owns it (the Social Security Number shown on the bond is not proof of ownership).

2. Co-Ownership

The co-owners own equal shares of the value of the bond.

3. Status as Resources

a. General

U.S. Savings Bonds are not resources during a mandatory retention period. They are resources (not income) as of the first day of the month *following the mandatory retention period.*

b. Co-ownership Without Access

A U.S. Savings Bond is not a resource to a co-owner if another co-owner has and will not relinquish physical possession of it.

C. Development and Documentation

1. Ownership-

a. Paper Bonds

Have the individual submit any bonds that he or she has an ownership interest in. Use the name(s) shown on the bond to determine ownership per B.1. or B.2. above.

b. Electronic Bonds

When an individual alleges ownership of electronic savings bonds, document bond ownership by asking the individual to download a record of his bond holdings from the Treasury Department. (see C.3.b below).

2. Status as Resources

If the individual alleges that he or she cannot submit a bond because a co-owner has and will not relinquish physical possession of it, obtain from the co-owner a signed statement verifying that the co-owner:

- has physical possession of the bond;
- will not allow the individual to cash the bond; and
- will not cash the bond and give the individual his or her share of its value.

3. **Value**
- a. **Series E, EE, and I paper bonds**
- **On-line Verification at:**
<http://www.publicdebt.treas.gov/sav/savcalc.htm>
 - *Current copy of the Table of Redemption Values for US Savings Bonds*
 - **Bank Verification** As a last alternative, obtain the value by telephone from a local bank and record it. The bank will need the series, denomination, date of purchase and/or date.
- b. **Series E, EE, and I electronic bonds**
- Ask individual to obtain his "Current Holdings" list from the Treasury web site at: <http://www.savingsbonds.gov/>
 - Use Current Holding Summary to verify number of bonds, face value, issue dates, confirmation numbers and value.
- c. **Series H and HH Bond After Maturity**
After maturity, the redemption value of a series H or HH bond is its face value. Verification of value per a. or b. above is unnecessary.
4. **Photocopy** Document the file with a photocopy or certification of the bond(s). See **S1140.010 C.** on photocopying U.S. Government obligations.
5. **Follow-up, if Appropriate** If an individual owns a U.S. Savings Bond which, upon maturity, may cause countable resources to exceed the limit, recontact the recipient shortly before the bond matures in order to redevelop the value of countable resources.

S1140.250 MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS

A. Introduction

1. **Bond** A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.
2. **Municipal Bond** A municipal bond is the obligation of a State or a locality (county, city, town, villages or special purpose authority such as a school district).
3. **Corporate Bond** A corporate bond is the obligation of a private corporation.
4. **Government Bond** A government bond, as distinct from a U.S. Savings Bond (see S1140.240), is a **transferable** obligation issued or backed by the Federal Government.

B. Operating Policy Municipal corporate, and government bonds are negotiable and transferable. Therefore, their value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial.

C. Development and Documentation Development and documentation instructions for stocks (S1140.220) also apply to bonds.

M1140.260 ANNUITIES (Effective for All Applications Received On or After December 1, 2004)

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

B. Operating Policy

- 1. An annuity containing a balloon payment is considered an available resource, and the value of the annuity is counted.*
- 2. An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable.*
- 3. A non-employment related annuity purchased by or for an individual using that individual's assets will be considered an available resource unless it meets all of the following criteria: the annuity (a) is irrevocable; (b) pays out principal and interest in equal monthly installments (no balloon payment) to the individual over the total number of months that equals the actuarial life expectancy of the annuitant; (c) names the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity not to exceed the amount of any Medicaid funds expended on the individual during his lifetime; and (d) is issued by an insurance company, bank, or other registered or licensed entity approved to do business in the jurisdiction in which the annuity is established. Payments from the annuity to the Commonwealth of Virginia cannot exceed the total amount of funds for long-term care services expended on behalf of the individual.*
- 4. Annuities issued prior to 12-01-04 which do not: (a) provide for the payout of principal and interest in equal monthly installments and (b) for which documentation is received from the issuing company that the payout arrangements cannot be changed will be considered to meet the above requirements once amended to name the Commonwealth of Virginia as the primary beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended on the individual during his lifetime.*
- 5. Have the individual submit documentation showing ownership of an annuity. If the owner is the Medicaid applicant or the applicant's spouse, the value of the annuity is a countable resource unless it meets the criteria listed in B.3 above.*

Note: For individuals applying for long-term care, the actuarial soundness of the annuity must be determined using policy in M1450.602. If the annuity is not actuarially sound, an uncompensated transfer of assets has occurred, and a penalty period may be imposed.

S1140.300 PROMISSORY NOTES, LOANS, AND PROPERTY AGREEMENTS

A. Introduction

- 1. General**

The context of the instruction in this section is the individual as the creditor (lender of money, seller of property) and, therefore, as the owner of the promissory note, loan, or property agreement.

See S1120.220 for additional information on notes, loans and property agreements.
- 2. Promissory Note**

A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered.
- 3. Loan**

A loan is a transaction whereby one party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under State law. A written loan agreement is a form of promissory note.
- 4. Property Agreement**

A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, and so on. Personal property agreements--e.g., pledges of crops, fixtures, inventory, etc.-- are commonly known as chattel mortgages.

B. Operating Policy

- 1. Real Estate Contracts Prior to Settlement**

When an individual enters into a contract for the sale of real estate, he or she owns two items until the settlement of the sale is completed: the real estate and the contract. The real estate is not a resource because the individual cannot convert it to food or shelter. The contract is a property agreement whose status and value as a resource must be determined in accordance with this section.
- 2. Value as a Resource Assumption**

Assume that the value of a promissory note, loan, or property agreement as a resource is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less than (or no CMV at all).



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Suite 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4612 (Fax)
804/343-0634 TDD)

CDPAS Waiver Criteria Review Form

CDPAS Service Coordinator:

Address:

Date of Approval for CDPAS Waiver:

RE:

SSN:

This person has met the level of care requirements to be admitted to the Consumer Directed Personal Attendant Services (CDPAS) Waiver and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

The CDPAS Service Coordinator is responsible to forward a copy of this letter to the individual's local department of social services eligibility worker.

DMAS Representative:

Date:

Phone: (804) 786-1465

B. Procedures

Use the following sections to evaluate an asset transfer:

- M1450.601 for a purchase of term life insurance.
- M1450.602 for a purchase of an annuity.
- M1450.603 for a transfer of assets into or from a trust.
- M1450.604 for a transfer of income.

M1450.601 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

**1. Policy Funds
Pre-need
Funeral**

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid recipient.

**2. Policy Funds
Irrevocable
Trust**

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

**3. Determine If
Transfer Is
Uncompensat-
ed**

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

- a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."
- b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."
- c. Compare the result to the term insurance policy's face value.
 - 1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.

- 2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.506 below.

EXAMPLE #1: Mr. C. uses \$5,000 from his checking account to purchase a \$5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

M1450.602 PURCHASE OF ANNUITY

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

Although usually purchased to provide a source of income for retirement, annuities are sometimes used to shelter assets so that the individuals purchasing them can become eligible for Medicaid. To avoid penalizing individuals who validly purchased annuities as part of a retirement plan, determine the ultimate purpose of the annuity, i.e., whether the annuity purchase is a transfer of assets for less than fair market value.

B. Policy

Determine if the annuity is a countable resource using the policy in M1140.260. If the expected return on the annuity is commensurate with a reasonable estimate of the beneficiary's life expectancy, the annuity is actuarially sound and its purchase is a transfer of assets for fair market value.

C. Procedures

Determine if the annuity is actuarially sound:

1. Use the life expectancy tables in section M1450.1000 at the end of this subchapter:
 - find the individual's age **at the time he/she purchased the annuity** in the "Age" column for the individual's gender ("Male" or "Female").
 - the corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.

his application, the worker learned that Mr. F. had transferred real estate assessed at \$10,000 on October 12, 1996. Since the transfer did not meet any of the criteria in M1450.501 and 502, a penalty period for Medicaid payment of long-term care services was determined. The 3-month period ran from October 1, 1996, through December 31, 1996.

On March 10, 1997, while Mr. F. was receiving Medicaid, he disclaimed an inheritance of \$30,000. Since the disclaimer is a transfer that did not occur in another penalty period, the agency calculated a new penalty period. *The penalty date is April 1, 1997, the first day of the month following March 1997, the month in which the transfer occurred.* The new period is 11 months from *April 1, 1997 through February 28, 1998.* Therefore, Mr. F. was ineligible for Medicaid payment of long-term care services from October 1, 1996 through December 31, 1996, and is ineligible for Medicaid payment of long-term care services from *April 1, 1997 through February 28, 1998*

J. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by his/her spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. One of two actions may be taken by the couple:

- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A enters a nursing facility and applies for Medicaid. Mrs. A transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A still has 24 months to run. Because Mrs. A is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A decide to have the penalty period divided between them. Therefore, both Mr. A and Mrs. A are ineligible for Medicaid payment of LTC services for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A leaves the facility and is no longer institutionalized. Mrs. A remains institutionalized. Because Mr. A is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A and 6 months for Mrs. A), must be imposed on Mrs. A. If Mr. A becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice

M1450.703 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

Note: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

B. Example #20 Full Compensation Received

Mr. G., who is in a nursing facility, applied for Medicaid on November 24, 2004. On October 10, 2004, he transferred his non-home real property worth \$30,000 to his son. The transfer did not meet any of the criteria in M1450.501, so a penalty period was imposed from October 1, 2004, through April 30, 2005.

On December 12, 2004, Mr. G.'s son paid medical bills for his father totaling \$30,000. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G.'s eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, 2004.

C. Example #21 Partial Compensation Received

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

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

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

institutionalization) were \$131,000. The spousal share is ½ of \$131,000, or \$65,500.

On the Medicaid Resource Assessment form, the worker lists the couple's resources as of December 1, 1995 as follows:

<u>Resource</u>	<u>Owner</u>	<u>Countable</u>	<u>Countable Value</u>
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	\$100,000
CD	Mr	Yes	\$ 31,000

\$131,000 Total Value of Couple's Countable Resources

\$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount (\$65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources at the time of application and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

- C. **“Institutionalized Spouse Resource Eligibility Worksheet”** Use the “Institutionalized Spouse Resource Eligibility Worksheet” to determine the institutionalized spouse's resource eligibility. The worksheet is in Appendix 4 to this subchapter.

M1480.231 SPOUSAL RESOURCE STANDARDS

- A. **Introduction** This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.
- | | | |
|---|-----------------|---------------|
| B. Spousal Resource Standard | <i>\$19,020</i> | <i>1-1-05</i> |
| | \$18,552 | 1-1-04 |
| C. Maximum Spousal Resource Standard | <i>\$95,100</i> | <i>1-1-05</i> |
| | \$92,760 | 1-1-04 |

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

- A. **Policy** An institutionalized spouse meets the resource eligibility requirements for Medicaid in the application month if the difference between the couple's total countable resources **at the time of application** and the spousal protected resource amount (PRA) is equal to or less than \$2,000.
1. **First Application** Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.
 2. **Subsequent Applications**
 - a. **Medicaid Eligibility For LTC Services Achieved Previously**
 If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources.** Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

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

B. Procedures

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

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

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

b. If the institutionalized spouse has Medicare Part A:

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

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

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

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

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

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

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

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

M1480.400 PATIENT PAY

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

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

\$1,561.25	7-1-04	
\$1,515	7-1-03	
- C. Monthly Maintenance Needs Allowance Maximum**

\$2,377.50	1-1-05	
2,319	1-1-04	
- D. Excess Shelter Standard**

\$468.37	7-1-04	
\$454.50	7-1-03	
- E. Utility Standard Deduction (Food Stamps Program)**

\$229	<i>1 - 3 household members</i>	<i>10-1-04</i>
\$283	<i>4 or more household members</i>	<i>10-1-04</i>
\$206	1 - 3 household members	10-1-03
\$253	4 or more household members	10-1-03

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).

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M1520.000 MEDICAID ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the recipient's circumstances that might *affect the recipient's continued Medicaid eligibility*.

An annual review of all of the recipient's Medicaid eligibility requirements is called a "renewal." A renewal of the recipient's eligibility must be completed at least once every 12 months.

When a Medicaid recipient no longer meets the requirements for the covered group under which he is enrolled, the eligibility worker must evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

The recipient must be informed of the findings of partial reviews and renewals and the action taken. The Notice of Action is used to inform the recipient of continued eligibility and the next scheduled renewal. The Advanced Notice of Proposed Action is used to inform the recipient of a reduction in benefits or termination of eligibility.

B. Procedures For Partial Review and Renewals

The policy and procedures in this subchapter are contained in the following sections:

- the requirements for partial reviews are in section M1520.100;
- the requirements for *renewals* are in section M1520.200;
- the policy and procedures for canceling a recipient's Medicaid coverage or reducing the recipient's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for extended Medicaid coverage are in section M1520.500;
- the policy and procedures for transferring cases within Virginia are in section M1520.600.

M1520.100 PARTIAL REVIEW**A. Recipient's
Responsibility**

The recipient has a responsibility to report changes in his circumstances which may affect his eligibility, *patient pay* or HIPP premium payments within 10 days from the day the change is known.

**B. Eligibility
Worker's
Responsibility**

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can *set a follow-up review in the MMIS for anticipated changes*. Examples of anticipated changes *include, but are not limited to, the receipt of SSA benefits and the delivery date for a pregnant woman*.

When changes in a recipient's situation are reported by the recipient or when the agency receives information indicating a change in a recipient's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the recipient's *continued* eligibility. *A reported increase in income and/or resources can be acted on without requiring verification. When a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group the reported change must be verified.*

A HIPP Application and Medical History Questionnaire must be completed when it is reported that a member of the assistance unit is employed more than 30 hours per week. The eligibility worker must report to the HIPP Unit at DMAS any changes in a recipient's situation that may affect the premium payment.

C. Time Standard

Appropriate agency action on a *reported change* must be taken within 30 days of the report.

**D. Covered Group
Changes****1. Newborn
Child**

When a child is born to a Medicaid-eligible woman (*including an emergency services alien certified for Medicaid payment for labor and delivery*), the only information needed to enroll the child in Medicaid (Child Under One covered group) is the child's name, *gender and date of birth* and that the child is living with the mother. This information may be reported through any reliable means, such as the hospital where the child was born, the medical practitioner, or the mother's managed care organization. The agency may not require that only the mother make the report.

An eligibility determination for a child born to a Medicaid eligible pregnant woman (including an emergency services alien certified for Medicaid payment for labor and delivery) is not required until the month in which the child turns one year old, unless there is an indication that the child is no longer living with the mother. If the child continues to live with the mother, an application and an eligibility determination must be completed prior to MMIS cut-off in the month the child turns one year old.

If the child is no longer living with the mother, the child's caretaker must be given the opportunity to file an application and receive an eligibility determination prior to the agency taking action to cancel the child's coverage.

2. Child Turns Age 6

When a child who is enrolled as an MI child turns age 6, the child's PD in MMIS will automatically be changed to 92 or 94. No action is required when the child is enrolled as PD 92. If the child is enrolled as PD 94, a partial review must be completed to determine if the child has creditable health insurance coverage. If the child does not have creditable health insurance, no additional action is required. If the child has creditable health insurance, the eligibility worker must cancel the child's enrollment in PD 94 effective the end of the month and reinstate coverage in PD 92 effective the first day of the following month. **Do not use change transactions to move a child to or from PD 94.**

3. SSI Medicaid Recipient Becomes a Qualified Severely Impaired Individual (QSII) – 1619(b)

When an SSI Medicaid recipient loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) - 1619(b) covered group may exist. A *partial* review to determine the individual's 1619(b) status in SVES must be completed. To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the PD to the appropriate PD.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all Medicaid recipients, with respect to circumstances that may change, at least every 12 months. An individual's continued eligibility for Medicaid requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.

The first 12-month period begins with the month of application for Medicaid. Subsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month of the last renewal. Monthly annual renewal lists are generated by the MMIS. These lists notify eligibility workers of recipients due for renewal.

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Individuals cannot be required to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth, Social Security number or United States citizenship.

*An ex parte renewal is an internal review of eligibility based on available information. By relying on information available, the agency can avoid unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. Local departments of social services are required to conduct renewals of ongoing eligibility through an **ex parte renewal** process when the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility, there is no resource test, and recipient is not receiving long-term care (LTC) services. Individuals in the SSI Medicaid covered group may have an ex parte renewal unless they reported ownership of non-exempt real property.*

If ongoing eligibility cannot be established through an ex parte renewal because the individual's covered group has a resource test or he receives LTC services or the ex parte renewal suggests that the individual may no longer be eligible for Medicaid, the agency must provide the individual the opportunity to present additional or new information using the Medicaid Renewal, form #032-03-669, (see M1520, Appendix 2) and verifications necessary to determine ongoing eligibility before the coverage is cancelled.

B. Renewal Requirements and Time Standard

The agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct eligibility renewals.

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. The recipient must be informed of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. The Advanced Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility. Renewals must be completed prior to cut-off in the 12th month of eligibility.

1. Ex Parte Renewal Process

The agency must utilize on-line systems information verifications that are available to the agency without requiring verifications from the individual or family and make efforts to align renewal dates for all

programs. The agency has ready access to Food Stamp and TANF records, some wage and payment information, information from SSA through the SVES, SDX and Bendex, and child support and child care files. Income verification less than 6 months old can be used unless the agency has reason to believe it is no longer accurate.

The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

When an ongoing F&C Medicaid recipient applies for Food Stamps or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.

The recipient is not required to complete and sign a renewal form when all information necessary to redetermine Medicaid eligibility can be obtained through an ex parte renewal process.

**2. Medicaid
Renewal Form
Required**

When a Medicaid Renewal form is required, the form must be sent to the recipient no later than the 11th month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the recipient to sign and return or can be mailed to the recipient for completion. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the recipient has been asked, but failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.

**C. Special Requirements
for Certain Covered
Groups**

**1. Pregnant
Woman**

A renewal of eligibility of an MI pregnant woman is not required during her pregnancy. Cancel her coverage as a pregnant woman effective the last day of the month in which the 60th day following the end of her pregnancy occurs. Reinstate coverage in the Family Planning Services (FPS) limited-coverage group effective the first day of the following month unless information available to the agency establishes her eligibility in a full-benefit covered group. Do not use change transactions to move an individual between full and limited coverage.

2. **FPS** The Medicaid eligibility of women in the FPS covered group must be *evaluated* 12 months following the end of the pregnancy. If eligible in a full-benefit covered group, *cancel her FPS coverage in the MMIS using cancel code "008" effective the last day of the month prior to the month of eligibility for full coverage, and reinstate full coverage the first day of the month of eligibility for full coverage. If eligible only for FPS, she is entitled to an additional 12 months of FPS coverage.*
3. **Newborn Child Turns Age 1** A renewal must be done when a newborn child turns age 1 and must include:
- completion and signing an application (see M0120.300)
 - SSN or proof of application
 - income for the MI or *FAMIS* child
 - income and resources for the MN child.
4. **MI Child Under Age 19 (FAMIS Plus)** The Medicaid eligibility of children in the MI Child Under Age 19 (*FAMIS Plus*) covered group must be renewed at least once every 12 months.
- When an enrolled MI child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is enrolled in FAMIS and there is no break in coverage. **Do not use change transactions to move a child between Medicaid and FAMIS.** If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child's Medicaid coverage
5. **MI Child Turns Age 19** When an MI child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.
- If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.
6. **Child Turns Age 21** When a *recipient* who is enrolled as a child under age 21 attains age 21, *determine if the recipient meets the definition for another covered*

group. If the recipient does meet the definition for another covered group, obtain the information to determine if the individual's resources and income are within the applicable limits. If the individual is eligible in another covered group, change the individual's aid category in the MMIS.

If the individual does not meet a definition for another covered group, send an advance notice and cancel the individual's Medicaid coverage because the individual does not meet a Medicaid covered group.

If the individual meets the definition for medically needy coverage but is not eligible because of income, send an advance notice and cancel the individual's Medicaid coverage because of excess income, and place the individual on a medically needy spenddown.

**7. IV-E FC and
AA and
Special
Medical Needs
AA Children
From Another
State**

For FC or AA children placed by another state's social services agency, verification of continued IV-E or non-IV-E special medical needs status, current address, and TPL can be obtained from *agency records*, the parent or the other state.

**8. Breast and
Cervical
Cancer
Prevention and
Detection Act
(BCCPTA)**

The BCCPTA Application/Redetermination, form #032-03-384, is used to redetermine eligibility for the BCCPTA covered group. The *renewal* form is available on-line at http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/General/Breast_and_Cervical_Cancer_Prevention-Treatment_Act_032-03-653.pdf. The recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

**9. SSI and QSII
(1619(b))
Covered
Group
Recipients**

For recipients enrolled in the SSI and QSII Medicaid covered groups, the ex parte renewal consists of verification of continued SSI or 1619(b) status by inquiring SVES. If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a Medicaid Renewal, form #032-03-699, must be completed and necessary verifications obtained to allow the eligibility worker to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

**D. Recipient Becomes
Institutionalized**

When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, eligibility as an institutionalized individual must be determined using the policies and procedures in chapter M14.

E. LTC

LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 (see Appendix 5 to subchapter M1410) for the annual renewal. The DMAS-122 must be updated at least every 12 months even when there is no change in the patient pay.

Ongoing eligibility for LTC recipients enrolled in the Medicaid SSI covered group can be established through an ex parte renewal, i.e., SVES inquiry.

M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION

M1520.401 NOTICE REQUIREMENTS

A. Policy

Following a determination that eligibility no longer exists or that the recipient's Medicaid services must be reduced, the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage. The proposed action becomes effective no earlier than the first day of the month following the 11-day period allowed for receipt of the "Advance Notice of Proposed Action" form.

Subsequent use of a Medicaid card to which the individual is not entitled could constitute a fraudulent act.

**B. Change Results in
Adverse Action****1. Services
Reduction**

When information is secured that results in a reduction of Medicaid services to the recipient or a reduction in the Medicaid payment for the recipient's services (when the patient pay increases), the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before the adverse action is taken. The adverse action must not be taken, however, if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer notifies the local agency of whether the appeal was filed before the action date.

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

**2. Adverse
Action
Resulting from
Computer
Matches**

When adverse action is taken based on information provided by computer matches from any source, such as IEVS, the Virginia Employment Commission (VEC) or SAVE, notice must be mailed at least ten (10) days before the effective date of the action, excluding the date of mailing and the effective date.

M1520.600 CASE TRANSFERS

- A. Introduction** Applications and ongoing cases are transferred only when the individual retains residence in Virginia.
- B. Nursing Facility and Assisted Living Facility (ALF)**
- When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.
- When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.
- C. DMHMRSAS Facilities** The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from DMHMRSAS facilities are in subchapter M1550. F&C cases are not transferred.
- D. DMAS Medicaid Unit (FAMIS Plus Unit) FIPS 976**
- The Medicaid cases approved by the DMAS Medicaid unit, FIPS 976, must be transferred to the local agency where the recipient lives. The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the DMAS Medicaid unit. Cases from the DMAS Medicaid unit do not require a *re-evaluation* until the annual *renewal* is due.
- Medicaid cases are not transferred from local agencies to FIPS 976.
- E. Locality to Locality**
- When a Medicaid applicant/recipient (including a Medicaid CBC waiver services recipient) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or a group home with 4 or more beds) in another locality within the State of Virginia, the following procedures apply:
- 1. Sending Locality Responsibilities**
- The sending locality (the locality from which the recipient has moved) must complete a partial review* of the case immediately and make an evaluation, based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality.
- If the *partial* review finds that eligibility no longer exists, the agency must take the necessary action, including advance notice to the individual, to cancel coverage and to cancel the case in the MMIS.
- If the *partial* review indicates that the recipient will continue to be eligible for Medicaid in the new locality, the sending locality must update the MMIS

with the new address and city/county code so that the new locality can accept the case for transfer. The *sending locality* must prepare the "Case Record Transfer Form" and forward it, with the case record, to the department of social services in the new locality of residence.

Pending applications must be transferred to the new locality for an eligibility determination.

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or at the agency's discretion the case may be sent via the courier pouch.

**2. Receiving
Locality
Responsibilities**

The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in the MMIS.

F. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

**1. Sending
Locality
Responsibilities**

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;
- note the spenddown period and balance on the case transfer form.

**2. Receiving
Locality
Responsibilities**

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

Commonwealth of Virginia
Department of Social Services (DSS)
Medicaid Program

Form box containing fields for CASE NUMBER, CASE NAME, DSS WORKER, DSS WORKER TELEPHONE, LOCAL AGENCY ADDRESS.

MEDICAID RENEWAL

Name: Address:

Please answer questions where the block is checked. Please return this form to your eligibility worker by: date

1. Has anyone moved into or out of your household since your last eligibility determination? No Yes If yes, tell us who moved in and who moved out.

2. List all the income received during the past month and attach verification. Include income from sources such as wages, retirement, Veteran's benefits, pensions, support, rental property, etc.

Table with 2 columns: Source, Amount. Includes dollar signs and blank lines for data entry.

3. Have you had a change in your health insurance since your last eligibility determination? No Yes If yes, list the company, coverage type, policy number and explain change.

4. Do you have any resources such as bank accounts, vehicles, life insurance, burial arrangements and/or real property? No Yes If yes, list each resource and attach verification of the current value of the resource.

Printed Name of Person Completing Form

Signature of Person Completing Form

Telephone Number

Date

Voter Registration. Check one of the following:

- () I am not registered to vote where I currently live, and I would like to register to vote here today.
() I am registered to vote at my current address.
() I do not want to apply to register to vote.
() I do want to apply to register to vote.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes.

Medicaid Renewal

FORM NUMBER - 032-03-669

PURPOSE AND USE OF FORM - To report information needed to complete Medicaid renewal.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The completed form is to be retained in the case file.

INSTRUCTIONS FOR PREPARATION OF FORM – If the form is mailed, it must be sent to the recipient no later than the 11th month of eligibility. The form may be completed by an agency representative during a telephone interview and sent to the recipient for a signature or mailed to the recipient for completion. The form may also be completed by the client during an in-office interview although a face-to-face interview is not required.

Verification of income or resources will normally be required.

Upon completion of the form, the EW must evaluate the information to determine continued eligibility for Medicaid. Recipient must be sent notice of action on the renewal.

If the form is completed and returned to the agency timely and additional information and/or verification is needed, the recipient must be notified in writing of the information and/or verification needed. If the household does not complete and return the form by VaMMIS cut-off in the 12th month of eligibility, the agency must send the Advance Notice of Proposed Action to close the case effective at the end of the 12th month.

M1640.100 APPEAL REQUEST PROCEDURES

- A. Appeal Definition**
1. An appeal is a request for a fair hearing. The request must be a clear, *signed* written expression by an applicant or recipient, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority.
 2. The appeal request must be written. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."
- B. Where to File an Appeal**
- Appeals must be sent to the Department of Medical Assistance Services, Appeals Division, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.
- C. Assuring the Freedom to Appeal**
- The freedom of appeal must not be limited or interfered with in any way. When requested to do so, the agency shall assist the appellant in preparing and submitting his request for a fair hearing.
- D. Appeal Time Standards**
1. A request for a hearing must be made within 30 days of receipt of notification that an application for medical assistance is denied, that it has not been acted upon with reasonable promptness, that a request for a medical service has been denied, or that the agency proposes to take any other action that will adversely affect receipt of medical assistance.
 2. Notification is presumed received by the applicant/recipient within three days of the date the notice was mailed, unless the applicant/recipient substantiates that the notice was not received in the three-day period through no fault of his/her own.
 3. The DMAS will, at its discretion, grant an extension of the time limit for requesting a fair hearing if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.
- E. Appeal Validation**
1. Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request is valid and will notify the appellant of the status of the appeal. A valid appeal is one that appeals an action over which the DMAS has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS may contact the agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the agency must immediately send a copy of the notice to the DMAS Appeals Division.

2. When an appeal is found valid, the DMAS will notify the appellant and request an appeal summary from the appropriate local agency.

M1650.100 LOCAL AGENCY APPEAL SUMMARY

A. Procedures

Once an appeal of an agency action has been validated, the agency must complete an "Agency Appeal Summary," form #032-03-805 (see Appendix 1 to this chapter). At least ten days prior to the hearing, the agency must send one copy of this form to each of the following:

1. Department of Medical Assistance Services, Appeals Division, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.
2. The local agency's assigned Medicaid Program *Consultant*.
3. The appellant or his authorized representative.

The agency must keep a copy of the appeal summary for its records.

M1660.100 THE HEARING PROCEDURE

A. The Hearing Officer

A qualified, impartial representative of the DMAS will conduct the hearing. This individual, the Hearing Officer, must not have been directly involved in the initial decision being appealed. The Hearing Officer will schedule the hearing at a time, date, and place convenient to the appellant and the involved agency. Some hearings may be held telephonically.

The Hearing Officer cannot discuss the substantive issues of the case with representatives of the local agency outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the agency's action prior to or after the hearing. However, as noted in M1620.100, it is appropriate to inform the Hearing Officer at any time before the hearing decision is issued when an action is taken that resolves the issue of the appeal. Also, it is appropriate to inform the Hearing Officer if the appellant indicates that he cannot attend the hearing and/or that he wishes to withdraw the appeal request.

B. Hearing Procedure

To best serve the appellant's interest, the hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings

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C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

FAMIS alienage requirements are different from the Medicaid alienage requirements. Citizens and qualified aliens who entered before August 22, 1996 meet the citizenship/alienage requirements and are not subject to time limitations.

*a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:*

- *refugees (see M0220.310 A. 2),*
- *asylees (see M0220.310 A. 4),*
- *veteran or active military (see M0220.311),*
- *deportation withheld (see M0220.310 A. 6), and*
- *victims of a severe form of trafficking (see M0220.313 A.52)*

*b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:*

- *lawful permanent residents (LPR),*
- *conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),*
- *aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and*
- *battered aliens, alien parents of battered children, alien children of battered parents.*

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements.

Appendix 7, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

2. SSN

A Social Security Account Number (SSN) or proof of application for a SSN (M0240) is **not** a requirement for FAMIS.

3. Assignment of Rights

The child's parent or legal custodian must meet the requirements for the assignment of rights to payment for medical care from any liable third party.

4. HIPP

Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to FAMIS.

**D. FAMIS
Nonfinancial
Requirements**

The child must meet the following FAMIS nonfinancial requirements:

**1. Age
Requirement**

The child must be under age 19. No verification is required.

The child no longer meets the age requirements for FAMIS as of the end of the month in which the child reaches age 19.

**2. Uninsured
Child**

The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

**3. State Employee/
Local Choice
Prohibition**

A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency. A child is also ineligible for FAMIS if he is a member of a family eligible for health benefits coverage on the basis of a family member's employment with a local governmental agency that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance.

**4. IMD
Prohibition**

The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated. Acquisition of health coverage for a child during enrollment in FAMIS is cause for termination.

B. Definitions

**1. Creditable
Coverage**

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

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

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

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

5. Insured means having creditable health insurance coverage or coverage under a health benefit plan.

6. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot**:

- have creditable health insurance coverage;
- have coverage under a group health plan (*TRICARE*, federal employee benefit plan, private group insurance such as *Anthem*, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to this chapter];
- be a member of a family eligible for health benefits coverage on the basis of a family member's employment with a public agency in the State that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance (see Appendix 2 to this chapter), or
- without good cause, have had creditable health insurance coverage terminated within 4 months prior to the month of application.

Good cause reasons are listed in E. below.

**D. Health
Insurance
Coverage
Discontinued**

A child is ineligible for FAMIS coverage if his creditable health insurance coverage was terminated without good cause within *4 months prior to the month for which eligibility is being established.*

Example: A child's health insurance was terminated without good cause in *November*. A FAMIS application was filed the *following February*. *The child is ineligible for February because his health insurance was terminated within 4 months of November. He may be eligible in March because his insurance was terminated more than 4 months prior to March.*

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

**E. Good Cause for
Dropping Health
Insurance**

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative with whom the child lives may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g. the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the premium exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

Documentation of the amount of the monthly premium of the discontinued insurance is required. If the amount of the premium is less than or equal to 10% of the family's current gross monthly income, a declaration from the family will be requested as to the amount of gross monthly income received at the time the insurance was discontinued.

1. Use the applicant's month-prior-to-application gross income verification.
2. Calculate 10% of the family's gross monthly income.
3. Compare to monthly premium amount.
4. If monthly premium is less than or equal to 10% of current gross monthly income:
 - a. Ask applicant "what was your family's gross income in the month in which you discontinued the health insurance (include all amounts of income received in that month)?" Document the applicant's statement in the record.
 - b. Calculate 10% of the family's gross monthly income (in the month in which the insurance was discontinued).
 - c. Compare to monthly premium amount.
 - 1) If monthly premium is less than or equal to 10% of this gross monthly income, good cause is NOT met. The children are not eligible for 4 months following the discontinuance of the insurance.
 - 2) If monthly premium is more than 10% of this gross monthly income, good cause is met and there is no waiting period for FAMIS.
5. If monthly premium is more than 10% of current gross monthly income, good cause is met and there is no waiting period for FAMIS.

M2120.300 NO CHILD SUPPORT REQUIREMENTS

A. Policy There are no child support requirements for FAMIS.

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. **FAMIS Assistance Unit**

The FAMIS assistance unit consists of:

- the child applicant under age 19;
- the parent(s) and stepparent who live in the home with the child; and
- any siblings, half-siblings, and stepsiblings under age 19 who live in the home with the child.

NOTE: Medicaid family/budget unit rules do not apply to FAMIS.
A child who is pregnant is counted as 1 individual; DO NOT COUNT the unborn child.

2. **Asset Transfer**

Asset transfer rules do not apply to FAMIS.

3. **Resources**

Resources are not evaluated for FAMIS.

4. **Income**

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS assistance unit.

The source and amount of all income other than Job Training Partnership Act (JPTA), Workforce Investment Act, and student income must be verified and counted. FAMIS uses the same income types and methods for estimating income as Medicaid (see chapter M07). There are no income disregards and no budget units in FAMIS.

5. **Spendedown**

Spendedown does not apply to FAMIS. If the family's gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

M2140.100 APPLICATION and CASE PROCEDURES

A. **Application Requirements**

The Application for Children's Health Insurance in Virginia (see Appendix 4) is the application form for FAMIS. The Application for Benefits or the ADAPT Statement of Facts *are also acceptable application/renewal forms* for FAMIS.

LOCAL CHOICE AGENCIES – effective 07/01/04*(Agencies added 7-1-04 are in bold)*

Altavista, Town of	Gate City, Town of
Amelia County Board of Supervisors	Gordonsville, Town of
Amelia County School Board	Goochland Schools and County
Amherst County Board of Supervisors	Greensville, County of
Amherst County Service Authority*	Greensville County School Board
Bath, County of	Grundy, Town of
Bedford County Public Service Authority	Halifax, Town of
<i>Blackstone, Town of</i>	Hampton Roads Regional Jail Authority
Blue Ridge Regional Jail Authority Until 07/01/05	Haysi, Town of
Bluefield, Town of	Highlands Juvenile Detention Center Commission
Brookneal, Town of	J.R. Horsley Soil and Water Conservation District
Brunswick County Public Schools	John Flannagan Water Authority
Buckingham, County of	King George, County of
Charlottesville-Albemarle Airport Authority	King William, County of
Carroll County Public Schools	Lebanon, Town of
Cedar Bluff, Town of	Lee County Department of Social Services
Center of Innovative Technology	Lee County Government
Central Shenandoah Planning District Commission	Lenowisco Planning District Commission
Central Virginia Regional Jail	Lonesome Pine Regional Library
Charlottesville-Albemarle Airport Authority	Lunenburg County Public Schools
Chesapeake Bay Bridge & Tunnel District	Luray, Town of
Clintwood, Town of	Mathews County
Coeburn, Town of	Middle Peninsula Regional Security Center
Coeburn-Norton-Wise Regional Waste Water	Monacan Soil & Water Conservation District
Colonial Heights, City of	Mount Jackson, Town of
Covington City School Board	Mount Rogers Planning District Commission
Craig County School Board	Narrows, Town of
Crater Youth Care Commission	Nelson, County of
Cumberland Mountain Community Services Board	New Kent, County (Only for County
Danville Redevelopment and Housing Authority	Administrators, Dept. Heads, and Constitutional
Dayton, Town of	Officers)
Dickenson County Department of Social Services	New Market, Town of (only if employee hired
Dinwiddie County Public Schools	before 12/16/96)
Dinwiddie, County of	New River Valley Agency on Aging
District 19 Community Services Board	New River Valley Planning District Commission
District Three Governmental Cooperative	New River Valley Regional Jail
Dublin, Town of	Northern Shenandoah Valley Regional
Eastern Shore Community Service Board	Commission
Edinburg, Town of	Northern Neck Regional Jail
Emporia, City of	Norton City Public Schools
Fairfax, City of	Norton, City of
Farmville, Town of	Page County Government
Franklin, City of	Pearisburg, Town of
Franklin City Public Schools	Pembroke, Town of
Franklin Redevelopment and Housing Authority	Pennington Gap, Town of
Fredericksburg City Public Schools	Peter Francisco Soil and Water Conservation
Front Royal, Town of	District
Glade Spring, Town of	

Petersburg, City of
Powhatan County Public Schools
Powhatan, County of
Prince Edward County Public Schools
Prince William Soil & Water Conservation District
Purcellville, Town of
Radford City Schools
Rappahannock, County of
Rappahannock Juvenile Center
**Regional Governor's School Global Economical and
Technology**
Rich Creek, Town of
Richlands, Town of
Richmond County Employees
Roanoke Valley-Alleghany Regional Commission
Roanoke Higher Education Authority
Round Hill, Town of
Scottsville, Town of
Saint Paul, Town of
Shenandoah County
South Central Wastewater Authority
Southampton County
Southampton County School Board
Southside Community Services Board
Southwest Virginia Regional Jail Authority
Spotsylvania County School Board
Strasburg, Town of
Sussex County School Board
Tazewell County
Tazewell County Department of Social Services
Tazewell County Public Schools (effective 10-01-04)
Tidewater Soil and Water Conservation District
Timberville, Town of
Urbanna, Town of
Virginia Biotechnology Research Park Authority
Virginia Dare Soil & Water Conservation District
Virginia Peninsulas Public Service Authority
Virginia Port Authority
Virginia Recreational Facilities Authority
Washington County School Board
Westmoreland County
Williamsburg-James City County Public Schools
Windsor, Town of
Wise County Board of Supervisors
Wise County School Board
Wise, Town of
Woodstock, Town of

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)