December 14, 2006

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #86

The following acronyms are used in this transmittal

- ABD – Aged, Blind, Disabled
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- COLA – Cost of Living Adjustment
- CNNMP – Categorically Needy Non-money Payment
- CBC – Community-based Care
- CMS – Centers for Medicare and Medicaid Services
- CPU – Central Processing Unit
- DCSE – Division of Child Support Enforcement
- DMAS – Department of Medical Assistance Services
- DMHMRSAS – Department of Mental Health, Mental Retardation and Substance Abuse Services
- DRA – Deficit Reduction Act of 2005
- FPL – Federal Poverty Level
- FPS – Family Planning Services
- IMD – Institution for Mental Diseases
- LDSS – Local Department of Social Services
- LIFC – Low-income Families with Children
- LTC – Long-term Care
- MI – Medically Indigent
- MMIS – Medicaid Management Information System
- MN – Medically Needy
- QI – Qualified Individuals
- QSI I – Qualified Severely Impaired Individual
- SLH – State and Local Hospitalization
- SOLQ-I – State Online Query Internet
- SSA – Social Security Administration
- SSI – Supplemental Security Income
Medicaid Transmittal #86 contains new, revised, clarified, and updated Medicaid eligibility policy as outlined within this letter.

New Policy

This transmittal contains a new covered group, MEDICAID WORKS, which is available to disabled individuals who are between the ages 16 and 65, who have countable income less than or equal to 80% FPL, countable resources less than or equal to $2,000 for an individual or $3,000 for a couple, and who are working or have a documented date for employment to begin in the future. Participants in MEDICAID WORKS will be allowed to retain Medicaid coverage by cost-sharing, including the possible payment of a premium, as long as they remain employed and their earned income is less than or equal to 200% of the FPL. Earned income that is retained will be excluded up to $26,356, the SSI 1619(b) earned income threshold amount for 2006, as long as the income is placed in a Work Incentive Account at a financial institution and the person continues working. A significant feature of the program is that once enrolled, the person’s income is evaluated as an assistance unit of one regardless of whether he is living with a spouse, or parent if under age 21. When the individual is unable to work for a temporary period of up to six months, he may remain in MEDICAID WORKS as long as he continues to pay any required premiums. For longer periods of unemployment, a “safety net” allows savings from earned income to be disregarded from all Medicaid eligibility determinations for up to a year after employment stops.

Policy has been added on retroactive FAMIS coverage for newborns who were born within three months prior to the application month. This policy was announced in Broadcast 3884 and was effective September 1, 2006. In order to receive retroactive coverage back to the date of birth, the application must be submitted within the newborn’s first three months of age. No retroactive coverage is available for applications submitted after the newborn’s third month.

Revised Policy

This transmittal contains a revision in the policy on the Newborn Children Under Age One covered group. This policy was announced in Broadcast 3993 and became effective for applications filed on or after November 14, 2006. Newborn children born to mothers determined eligible for Medicaid payment of emergency services only (i.e. emergency services aliens) are no longer considered to be deemed eligible for Medicaid as “certain newborns.” An application for the child must be received prior to the enrollment of the child and the mother must be determined eligible for, and enrolled in, Medicaid effective the date of the child’s birth. Upon receipt of the application for the child and determination of the mother’s Medicaid eligibility, the child is enrolled in Medicaid as an MI Child under age 6 in aid category 090 or 091, depending on whether the reported countable income is less than or equal to 100% FPL or is over 100% FPL (but is not over 133% FPL). Verifications and documentation of the child’s Medicaid eligibility may be postponed until after the initial enrollment. After enrollment, the eligibility worker must request birth certificate verification from VDH. The worker must also request other necessary verifications from the parent(s), including verification of household income and proof of application for the child’s SSN. If the application submitted by the parent does not contain a statement of identity for the child, an affidavit of the child’s identity must also be obtained. Note that the enrollment prior to the receipt of verifications applies only to the
child, not to the mother. All verifications necessary to determine the mother’s Medicaid eligibility must be received before the child can be initially enrolled.

The policy on accepting photocopies of Virginia birth certificates has been revised in this transmittal. A copy of a Virginia birth certificate that is in the existing LDSS agency record, or is presented by an individual as verification, is acceptable temporarily while the LDSS agency waits for certification of the copy as a true copy by VDH. The agency may approve or renew coverage if the individual meets all other eligibility requirements. The agency must obtain certification of the copy by VDH, and the certified copy must be placed in the record when received. Acceptance of a photocopied birth certificate does not apply to individuals born outside of Virginia or for documentation of an individual’s identity.

Another significant policy revision contained in this transmittal is the removal of the policy that requires a parent or caretaker-relative to cooperate with DCSE in the pursuit of medical support when applying for Medicaid benefits for that individual and a child. The applicant’s signature on the application meets the requirement to cooperate with the pursuit of medical support. At application, the LDSS worker is only required to give the applicant the DCSE Fact Sheet. DCSE services should be explained and offered to custodial parents and guardians when there is an absent parent; however, the use of DCSE services is completely voluntary. The parent, guardian, or caretaker-relative is still required to provide information on TPL, if applicable.

The income limit for the FAMIS MOMS Program is revised in this transmittal. The 2006 Virginia General Assembly approved an increase in the FAMIS MOMS income limits from 150% of the FPL to 166% of the FPL. The increase, which was announced in Broadcast 3890, was effective September 1, 2006.

Clarifications

Clarifications to policy contained in this transmittal include the following: the name listed in SVES or SOLQ-I must be used when an individual reports a name change; authorized representatives and family substitute representatives must be at least age 18; an application for medical assistance is an application for the Medicaid, FAMIS, FAMIS Plus, FAMIS MOMS, and SLH programs; the emergency services enrollment period for women who received a labor or delivery-related service includes the day of discharge; a man listed on the application as the father meets the definition of an acknowledged father; the child care exclusion is only given to two-parent households when both parents are working; the principle of equitable ownership may be applied to automobiles; and all income made available to the community spouse by the institutionalized spouse must be considered before additional resources can be protected by a DMAS hearing officer.

Also clarified in this transmittal are the situations in which a new application is or is not required, the entitlement dates for individuals age 21-64 who are admitted to an IMD, when the SSN must be verified, and the information that is needed when a case is transferred to the FAMIS CPU.

Updates

The SSI amounts, ABD deeming standard amount, ABD student child earned income exclusion, CBC personal maintenance allowance, spousal resource standard, spousal resource maximum, maximum monthly maintenance needs allowance, Medicare premiums, and COLA amounts for 2007 are included in this transmittal and are effective January 1, 2007. The updated LTC utility standard deduction, effective October 1, 2006, is also included in this transmittal. The updated amount was announced in Broadcast 3902. The utility standard deduction is used to determine if the community spouse’s shelter expenses exceed the excess shelter standard.
**Effective Date**

Unless otherwise specified in this transmittal letter, the new policy, policy revisions, clarifications, and updates contained in this transmittal are effective January 1, 2007.

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<tbody>
<tr>
<td>Subchapter M0110</td>
<td>Subchapter M0110</td>
<td>On page 5, clarified an application for medical assistance. On page 6, clarified that an authorized representative and a family substitute representative must be age 18 or older. On page 7, added the definition of medical assistance. Page 8 is a runover page.</td>
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<tr>
<td>pages 5-8</td>
<td>pages 5-8</td>
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<tr>
<td>Subchapter M0120</td>
<td>Subchapter M0120</td>
<td>Updated the Table of Contents. On page 1, added the definition of an authorized representative. On pages 2, 4 and 5, clarified that a family substitute representative and an authorized representative must be age 18 or older. Page 3 is a runover page. Page 6 is reprinted. On page 7, corrected the format. On pages 8-10, clarified the application policy and replaced the references to the appendices with links to the forms on the local agency intranet. On page 10, added the Application for Benefits form is also an application for SLH. Pages 11-13 are runover pages. On pages 14-15, added a new section of policy about when an application is required. Deleted Appendices 2-8 and renamed the BCCPTA Medicaid Application form Appendix 2.</td>
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<td>Table of Contents</td>
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<td>pages 1-13</td>
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<td>Appendices 2-8</td>
<td>Appendix 2</td>
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<tr>
<td>Subchapter M0130</td>
<td>Subchapter M0130</td>
<td>Updated the Table of Contents and deleted the appendices. On page 1, added the term “medical assistance” and that an Application for Benefits is for Medicaid, FAMIS/FAMIS MOMS and SLH. On pages 1 and 3, deleted references to the appendices and inserted the links to the referenced</td>
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<td>pages 1-9</td>
<td>pages 1-11</td>
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<td>Appendices 1 and 2</td>
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forms. Page 2 is a runover page. On page 3, clarified that an application for medical assistance is an application for SLH if the application is dated within 30 days of receiving a hospital service. On pages 3 and 4, clarified the requirements for the individual’s name when the name used does not match the name on Social Security records. On pages 4 and 5, added revised policy for newborns born to mothers eligible for emergency services only. On page 6, changed the SSN exception for children under 1 to exclude newborns of emergency services aliens, added the link to the Enumeration Referral Form and added instructions for entering a pseudo SSN in the computer systems. On page 7, deleted the reference to the appendix and inserted the link to the referenced legal presence affidavit form. On page 8, updated the SOLQ-I title and acronym. Page 9 is a runover page. On page 10, added the link to the MMIS User’s Guide for DSS, deleted the reference to the appendix and inserted the link to the referenced notice form. Page 11 is a runover page. Deleted Appendices 1 and 2.

Revised the references to the appendices in the Table of Contents. Page 1 is reprinted. On page 2, exception 1 and item B.1. are changed for newborns of emergency-services-only aliens. Page 3 is a runover page. On page 4, clarified that photocopies of Virginia birth certificates are acceptable when the agency secures certification of the copy by VDH.
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<tr>
<td>Subchapter M0250</td>
<td>Subchapter M0250</td>
<td>Updated the Table of Contents, and deleted the appendices. On pages 1 and 2, clarified the assignment of rights policy for an individual applying for himself and/or another person. On pages 3 and 4, changed the policy regarding the pursuit of</td>
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<td>pages 1-11</td>
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<td>Appendices 1-4</td>
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<td>On page 4a, removed the reference to Appendix 9, added a link to the Affidavit of Identity form available on the LDSS Intranet, and clarified the hierarchy policy. Pages 4b-4g are runover pages. On page 4h, removed the references to Appendices 7 and 8 and added links to the affidavit forms for citizenship available on the LDSS Intranet. Page 4i is a runover page. On page 4j, removed the reference to Appendix 9 and added the link to the Affidavit of Identity form available on the LDSS Intranet. Page 4k is a runover page. On page 4l, clarified the policy on reasonable opportunity to provide citizenship and identity documentation. Pages 4m-4p are runover pages. On page 17, corrected a section reference. Pages 18, 21 and 23 are reprinted. On page 22, clarified that a newborn child born to a mother who is an emergency services alien is not deemed eligible for Medicaid, and an application must be filed for the child to be eligible. On pages 22 and 24, clarified that the end date of enrollment includes the date of discharge when the emergency service received was related to labor and delivery. Because the links to the intranet forms were added, Appendices 7-9 were removed, and Appendix 10, Proof of U.S. Citizenship and Identity for Medicaid, was renamed Appendix 7.</td>
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<td>Chapter M03 Table of Contents</td>
<td>Chapter M03 Table of Contents</td>
<td>Updated the Table of Contents.</td>
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<td>Subchapter M0310 Pages 3, 4</td>
<td>Subchapter M0310 Pages 3, 4</td>
<td>On page 3, updated the ABD covered groups. Page 4 is reprinted.</td>
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<td>Subchapter M0320 Table of Contents</td>
<td>Subchapter M0320 Table of Contents</td>
<td>Updated the Table of Contents. On page 1, updated the ABD covered groups. Pages 2 and 11 are reprinted. On page 12, the cost-of-living calculation and Medicare Premiums for 2007 are added. On page 23, updated the ABD covered groups. Pages 24 and 41 are reprinted. On page 42, clarified that QI funds are only maintained in MMIS for the current and previous year. On page 42c, clarified that an MMIS edit prevents enrollment in QI outside of the allowable period. Page 42d is reprinted. On pages 45-46e, added policy for the MEDICAID WORKS covered group. On page 46f, clarified that a newborn child born to an emergency-services-only alien does not meet the definition of the Newborn Children covered group. On page 49, clarified that FPS coverage is limited to women who have not had a sterilization procedure. On page 50, clarified that cooperation with DCSE is no longer a nonfinancial requirement. On page 50a, clarified that MMIS will cancel FPS coverage for women who have had a sterilization procedure. On page 50b, clarified the age range for the MI Child covered group. Page 53 is reprinted. On page 54, clarified</td>
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<td>Subchapter M0520</td>
<td>Subchapter M0520</td>
<td>which aid categories are used for various individuals enrolled in the LIFC covered group.</td>
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<tr>
<td>pages 1-4</td>
<td>pages 1-4</td>
<td>Pages 1 and 4 are reprinted. On pages 2 and 3, the definition of an acknowledged father was clarified to include the man listed as the child's father on the application when he is not married to the child's mother.</td>
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<tr>
<td>Subchapter M0530</td>
<td>Subchapter M0530</td>
<td>In Appendix 1, revised the ABD deeming allocations for 2007.</td>
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<td>Appendix 1</td>
<td>Appendix 1</td>
<td>Updated the Table of Contents. On pages 17, 18 and Appendix 1, clarified that the child care/incapacitated adult care expense exclusion is applicable only when the expense is required because of the individual's employment or the seeking of employment. When both parents of a child are in the home, both parents must be employed or seeking employment in order to apply the exclusion for child care/incapacitated adult care expenses. Page 19 is a runover page.</td>
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<td>Subchapter M0720</td>
<td>Subchapter M0720</td>
<td>Updated page i of the Table of Contents. Page ii is reprinted. On page 17, added policy on rebutting ownership of an automobile. Pages 18 and 18a are runover pages.</td>
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<td>Updated the Table of Contents. On pages 17, 18 and Appendix 1, clarified that the child care/incapacitated adult care expense exclusion is applicable only when the expense is required because of the individual's employment or the seeking of employment. When both parents of a child are in the home, both parents must be employed or seeking employment in order to apply the exclusion for child care/incapacitated adult care expenses. Page 19 is a runover page.</td>
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<td>pages 16a-17</td>
<td>pages 17-19</td>
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<td>Appendix 1</td>
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<td>Subchapter M0810</td>
<td>Subchapter M0810</td>
<td>On page 1, revised the income limits for the CNNMP Protected covered groups for 2007. On page 2, revised the 300% SSI income limits for 2007.</td>
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<td>pages 1, 2</td>
<td>pages 1, 2</td>
<td>Pages 29 and 32 are reprinted. On pages 30 and 31, revised the Blind or Disabled Student Child Earned Income Exclusion for 2007.</td>
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<td>Subchapter M0820</td>
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<td>pages 29-32</td>
<td>pages 29-32</td>
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<td>Subchapter S1130</td>
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<td>Table of Contents, pages i, ii</td>
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<td>pages 17, 18</td>
<td>pages 17, 18a</td>
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<td>Subchapter M1470</td>
<td>Subchapter M1470</td>
<td>On pages 11 and 12, added information about the electronic resource assessment workbook available online. Page 13 is a runover page. On pages 14, 16a, 17, 18, and 31, added information about the electronic resource assessment workbook available online. On page 18, also revised the spousal resource standards for 2007. Page 32 is a runover page. Page 65 is reprinted. On page 66, revised the utility standard deduction, effective October 1, 2006, and the maximum monthly maintenance needs allowance, effective January 1, 2007. On page 67, added information about the electronic patient pay workbook and worksheet available online. Page 68 is a runover page. On page 69, revised the personal maintenance allowance for 2007. Pages 70 and 71 are reprinted. On pages 72 and 73, removed the policy on the community spouse not accepting the monthly income</td>
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<td>pages 21, 22</td>
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<td>pages 31, 32</td>
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<td>Subchapter M1510</td>
<td>Subchapter M1510</td>
<td>Updated the Table of Contents, and deleted the appendix. On pages 1-4, clarified that the eligibility determination includes SLH if the applicant applied within 30 days of the hospital service and he is not eligible for Medicaid. On pages 5-7, revised the ongoing entitlement policy for applicants in ineligible institutions, such as IMDs. Page 8 is a runover page. On page 9, deleted the reference to Appendix 1 and replaced it with the link to the intranet form. Pages 10 and 11 are runover pages. On pages 12 and 13, corrected the references to the MMIS and CMS. On pages 14 and 15, clarified the TPL and SSN follow-up policy. On pages 16 and 17, added the new section of follow-up policy and procedures for newborns of emergency-service-only aliens. Deleted Appendix 1.</td>
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<td>allowance because the “income first” rule requires that all income from the institutionalized spouse that could be made available to the community spouse be considered before additional resources are allocated to the community spouse. Page 74 is reprinted.</td>
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<td>pages 1-14</td>
<td>pages 1-17</td>
<td>significant changes</td>
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<td>Appendix 1</td>
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<td>Subchapter M1520</td>
<td>Subchapter M1520</td>
<td>Updated the Table of Contents, and deleted the appendices. On pages 1 and 2, changed references to recipients to “enrollee,” clarified policy for reported changes requiring a partial review, and clarified that newborns of emergency-services-only aliens are not certain newborns. On page 3, added SOLQ-I to the source of verification of QSII eligibility. On pages 4 and 5, clarified the renewal policy and procedures, deleted</td>
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<td>Appendix 1</td>
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- **Subchapter M1550 Appendix 1**
- **Chapter M17 Table of Contents Pages 1-6**
- **Appendix 1, pages 1 and 2**
- **Appendix 2, pages 1 and 2**

Updated the caseload assignments for the DMHMRSAS Facilities Medicaid Technicians.

- **Subchapter M1550 Appendix 1**
- **Chapter M17 Table of Contents Pages 1-6**
- **Appendix 1, pages 1 and 2**
- **Appendix 2, pages 1 and 2**

Corrected the chapter name in the Table of Contents. Page 1 is reprinted. On page 2, revised the list of information that must be provided to the DMAS Recipient Audit Unit. Page 3 is reprinted. On page 4, revised some of the text for added clarity. On page 5, clarified that cases should be cancelled using the cancel code for fraud. On page 6, clarified that DMAS will notify the agency of the results of a fraud investigation. On Appendix 1, pages 1 and 2, updated the Notice of Recipient Fraud/Non-fraud Overissuance form and its references to appendices, and added links to the forms on the local agency intranet. Page 6 is a runover page. On page 7, corrected the link to the BCCPTA renewal form. On page 8, deleted the reference to the appendix and added links to the intranet LTC Renewal and Advance Notice of Action forms. Page 9 is a runover page. On page 10, added the link to the Client Information Document report on the intranet. On pages 11-20, clarified the extended Medicaid policy and procedures, and deleted the Transitional Medicaid section. On page 21, updated the title of the DMAS FAMIS Plus Unit. Page 22 is a runover page.
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<tr>
<td>Chapter M21</td>
<td>Chapter M21</td>
<td>Updated the Table of Contents. On page 1 and subsequent pages where appropriate, references to Medicaid were changed to FAMIS Plus. On page 1, added the new FAMIS retroactive coverage policy for a child who was born within the 3 months prior to the FAMIS application month. Pages 2 and 4 are runover pages. On page 3, changed the reference to the FAMIS Alien Eligibility Chart to Appendix 3. On page 5, changed the reference to the State Agency Listing to Appendix 2. On pages 6 and 7, reformatted the policy. On page 8, deleted the reference to Appendix 4; corrected the title, and added a link to the Health Insurance For Children and Pregnant Women application; and clarified that income must be verified for a FAMIS eligibility determination. On page 9, added the new policy regarding retroactive FAMIS for newborns. On page 10, clarified that copies of income verification must be sent with the case material to the CPU. Page 11 is a runover page. On page 12, clarified that when a reported income change causes a child's eligibility to change from FAMIS Plus to FAMIS, the income must be verified; corrected the link to the Children's Health Insurance Communication Form; and deleted</td>
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<td>Table of Contents</td>
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<td>instructions to remind the LDSS to attach the necessary supporting information. On Appendix 2, page 1, updated the DMAS Director's name. Appendix 2, page 2 is reprinted.</td>
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<tr>
<td>pages 1-14</td>
<td>pages 1-15</td>
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<td>Appendix 3</td>
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<tr>
<td>Chapter M22</td>
<td>Chapter M22</td>
<td>reference to Appendix 3. Pages 13-15 are runover pages. Changed the appendix number of the FAMIS Alien Eligibility Chart to Appendix 3.</td>
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<tr>
<td>pages 1, 2</td>
<td>pages 1, 2</td>
<td>On pages 1, 2 and 6, the income limit for FAMIS MOMS is changed to 166% of the FPL. Page 5 is reprinted. Appendix 1 is changed to show the 166% FPL income limits that were effective September 1, 2006.</td>
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<td>pages 5, 6</td>
<td>pages 5, 6</td>
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Please retain this transmittal letter in the back of Volume XIII

![Signature]

Anthony Conyers, Jr.
Commissioner

Attachment
(2) Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.

(3) The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:

- All personal information about the client except as provided in §2.2-3704 and §2.2-3705,
- The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.

(4) Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified. When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

**M0110.200 Definitions**

**A. Adult Relative**

means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.

**B. Applicant**

means an individual who has directly or through his authorized representative made written application for Medicaid at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.

**C. Application for Medical Assistance**

means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. An application for medical assistance is an application
for the Medicaid, State and Local Hospitalization (SLH), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS programs.

D. Attorney-In-Fact (Named in a Power of Attorney Document) means a person authorized by a power of attorney document (also referred to as a “POA”) to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. A power of attorney document does not necessarily authorize the attorney-in-fact to apply for Medicaid on behalf of the applicant. The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative as long as the person for whom the attorney-in-fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney-in-fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine that it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.

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

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

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

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

F. Child means an individual under age 21 years.

G. Competent Individual means an individual who has not been judged by a court to be legally incapacitated.

H. Conservator means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.
1. **Family Substitute Representative**

means a spouse *age 18 or older* or designated relative *age 18 or older* who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.

2. **Guardian**

means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

3. **Incapacitated Individual**

means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.

4. **Legal Emancipation of a Minor**

means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

5. **Medical Assistance**

means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, State and Local Hospitalization (SLH), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS.

**M0110.300 Availability of Information**

6. **Information Required to be Given to the Applicant**

1. **Explanation of Medicaid Program**

The agency must inform the applicant about Medicaid eligibility requirements, covered services, use of the Medicaid card, recovery (3rd party, lawsuits and estate) of funds paid, and the applicant's rights and responsibilities. This information must be given to the applicant in written form and verbally, if appropriate.

The following materials must be given to the individuals specified below:

- The booklet "Virginia Social Services Benefit Programs,” form # 032-01-002, contains information about the Medicaid Program and must be given to all applicants;
• The Division of Child Support Enforcement (DCSE)’s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; and

• The “Virginia Medicaid Handbook” must be given to all recipients and must be given to others upon request.

Applicants may also be given Medicaid Fact Sheets as appropriate.

2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

All Medicaid applicants who are under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Information on the availability and benefits of EPSDT must be provided for all applicants under age 21 within 60 days of the date that eligibility is determined. EPSDT information is included in the booklet "Virginia Social Services Benefit Programs."

3. Voter Registration

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each TANF, Food Stamp, and Medicaid applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

In complying with the requirements of the NVRA, local agency staff must provide each applicant and applicant the same degree of assistance in completing his/her voter registration application as they do in completing the application for public assistance.

a. Exceptions to Offering Voter Registration

The only exception to offering voter registration application services is when the applicant:

• has previously indicated that he/she is currently registered to vote where he/she lives,

• there is a completed agency certification form in the applicant's case record indicating the same, and

• the applicant has not moved from the address where he/she stated that he/she was registered to vote.

b. Voter Registration Application Sites

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, Food Stamp, and Medicaid assistance. Voter registration application services are also offered by out-stationed staff taking Medicaid applications at hospitals or local health departments and by Medicaid staff at the state's Mental Health, Mental Retardation, and Substance Abuse facilities.
# TABLE OF CONTENTS

## M01 MEDICAID APPLICATION

### M0120.000 MEDICAL ASSISTANCE APPLICATION

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Apply</td>
<td>M0120.100</td>
</tr>
<tr>
<td>Who Can Sign the Application</td>
<td>M0120.200</td>
</tr>
<tr>
<td>Medical Assistance Application Forms</td>
<td>M0120.300</td>
</tr>
<tr>
<td>Place of Application</td>
<td>M0120.400</td>
</tr>
<tr>
<td>Receipt of Application</td>
<td>M0120.500</td>
</tr>
<tr>
<td>When an Application Is Required</td>
<td>M0120.600</td>
</tr>
</tbody>
</table>

## Appendices

- Sample Letter Requesting Signature | Appendix 1 | 1
- The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384 | Appendix 2 | 1
M0120.000 Medical Assistance Application

M0120.100 Right to Apply

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

M0120.200 Who Can Sign the Application

A. Patients in DMHMRSAS Facilities
   Patients of any age in the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities may have applications submitted and signed by DMHMRSAS staff. The DMHMRSAS facilities are listed in subchapter M1550.

B. Applicants Age 18 or Older
   The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the “committee” for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. If the applicant cannot sign his or her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

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

   Witness's signature:_____________

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

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

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

EXCEPTION: Patients in the DMHMRSAS facilities may have applications submitted by DMHMRSAS staff.
2. **Family Substitute Representative**

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is age 18 years or older and is willing to take responsibility for the applicant’s Medicaid business will be the applicant’s “family substitute” representative. The family substitute representative will be, in this preferred order, the applicant’s:

- spouse,
- child,
- parent,
- sibling,
- grandchild,
- niece or nephew, or
- aunt or uncle.

3. **No Family Substitute Representative**

If the applicant is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, the applicant’s inability to sign the application must be verified. Verification is by a written statement from the applicant’s doctor that says that the applicant is not able to sign the Medicaid application because of the applicant’s diagnosis or condition. Follow these procedures:

a. Determine if anyone has begun the process to have a guardian or conservator appointed for the applicant.

b. If action has been initiated to obtain a guardian for the applicant, meaning a court guardianship hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10 day period, continue to pend the application until the guardian or conservator is appointed. If the application pends for 45 days, send a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-003, to the applicant to extend the pending application.

Once the guardian/conservator has been appointed, request verification of the appointment and that the application be signed by the guardian or conservator. Retain a copy of the application and mail the original application to the guardian/conservator. Allow 10 days for the signed application and guardian/conservator papers to be returned. If the application form and guardian/conservator papers are not returned to the agency by the specified date, deny the application because it is invalid.

c. If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.
If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by APS.

Continue to pend the application until the APS investigation is completed. If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the applicant, or the applicant must sign a statement designating an authorized representative. Give the applicant 10 working days to return the signed application to the agency.

d. If the application form is not signed by the applicant or the authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

4. Procedure for Who Can Sign the Application

When preparing to determine the Medicaid eligibility of an individual age 18 or older, examine the application to determine if the applicant can complete and sign the application form or if the applicant has an authorized representative. Ask the following questions:

Has the applicant been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record?

YES: The authorized representative is the appointed conservator or guardian. STOP.

NO: The applicant is competent. Does the applicant have an attorney in fact who has the power of attorney to apply for Medicaid for the applicant as evidenced by a copy of the power of attorney document in the record?

YES: The authorized representative is the attorney in fact. STOP.

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for Medicaid on his behalf?

YES: The authorized representative is the person or organization authorized by the applicant to represent him. STOP.

NO: Is the applicant able to sign or make a mark on a Medicaid application form?

YES: Ask the applicant for his signature or mark on the application form or for a written statement authorizing someone to apply for Medicaid on his behalf.
Give the applicant 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, DENY MEDICAID because of an invalid application.

NO: Does the applicant have at least one of the following who is age 18 or older:

- spouse,
- child,
- parent,
- sibling,
- grandchild, niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant’s doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny Medicaid.
C. Applicants Under Age 18

1. Child Applicant

A child under age 18 years is not legally able to sign his own Medicaid application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals who is age 18 or older must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child under 18 years of age is married and living with his spouse who is age 18 or older, the child’s spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whomever the child is living with is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 calendar days for this verification to be provided.

If the verification is provided within the 10-calendar-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 calendar days, send a notice to the applicant explaining that the application pending period will be extended.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 calendar days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.
c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Family Services worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 calendar days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child’s signature on the application. If the application is mailed to the child, allow 10 calendar days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, the custodial adult, or the emancipated child and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

3. Foster Care Child

a. Non-IV-E

The Medicaid application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, the parent or legal guardian must sign the Medicaid application.

b. IV-E

A separate Medicaid application is not required for a child in the custody of a Virginia public or private child-placing agency whose IV-E eligibility has been evaluated using the Title IV-E Foster Care and Medicaid Application/Redetermination. If there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign a Medicaid application for the child.

4. Adoption Assistance & Special Medical Needs Children

a. Placed by a Virginia Agency

A separate Medicaid application is not required for a IV-E adoption assistance child. A Medicaid application is required for all other adoption assistance children placed by a Virginia agency.

b. Placed by Another State

IV-E and non-IV-E special medical needs children who have been placed for adoption by another state through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have a form 6.01
which verifies eligibility for Medicaid. A separate application is not required. All states and territories EXCEPT New York, Vermont, Wyoming, Puerto Rico and Virgin Islands are members of ICAMA.

A Medicaid application is required for all other adoption assistance children placed by another state.

D. Deceased Applicant

An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions were met:

- the deceased received a Medicaid-covered service on or before the date of death, and
- the date of service was within a month covered by the Medicaid application.

If the above conditions were 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 Medical Assistance Application Forms

A. General Principle – Application Required

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

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

1. Exception for Certain Newborns

   EXCEPTION: A child born to a mother who was Medicaid eligible at the time of the child’s birth (NOT including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child’s birth (see M0320.301). An application for the child is not required. The child remains eligible for Medicaid to age 1 year as long as the mother remains eligible for Medicaid, or would be eligible if she were still pregnant, and they live together.

2. ADAPT Request for Assistance

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

B. Medicaid and FAMIS Application Forms

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

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

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

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

1. Application For Benefits

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

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

3. **Medicaid Application/Redetermination for Medically Indigent Pregnant Women**

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

4. **Health Insurance for Children and Pregnant Women**

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

5. **BCCPTA Medicaid Application**

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).

6. **ADAPT Statement of Facts**

The signed ADAPT Statement of Facts (SOF) is an application used for children and pregnant women. 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.

7. **Title IV-E Foster Care & Medicaid Application/Redetermination**

The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant’s guardian.

Other forms that serve as Medicaid and FAMIS application forms are listed in section M0120.300.C., below.
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 Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and AA children and non-IV-E FC children in the custody of a local agency in Virginia. This form is not used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement or is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.

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

D. SLH Application Form

The following form has been prescribed as the application form for SLH:

- Application for Benefits, form #032-03-824, also referred to as the Combined Application.

M0120.400 Place of Application

A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of 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

1. Foster Care

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

a. Title IV-E Foster Care

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

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

b. State/Local Foster Care

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

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

2. Adoption Assistance

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

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

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

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

C. Institutionalized Individual (Not Incarcerated)

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

**Exception:** If the applicant is applying for or receives food stamps, responsibility for processing the Medicaid application and determining Medicaid eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.
If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

D. Individuals in DMHMRSAS Facilities

1. Patient in a DMHMRSAS Facility

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

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

2. Patient Pending Discharge

a. General Policy

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

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

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

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

If the patient is found eligible, he is not enrolled in the Medicaid program until he has been discharged from the institution.
b. Pending Discharge to a Facility

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

c. Pending Discharge to the Community

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

E. Virginia Veteran’s Care Center

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

F. Incarcerated Individuals

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

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

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

- The correctional facility staff will complete the Medicaid application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.

- The correctional facility staff will request a pre-admission screening for nursing home care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.
M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit a written application for Medicaid only or may apply for Medicaid in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

B. Qualified Individuals (QI)

Eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. A QI must submit a new Medicaid application on or after January 1 of each year in order to receive continued coverage. Applications for QI coverage for an upcoming year may not be taken until January 1 of that year (see M0320.208).

C. Application Date

The application date is the earliest date the signed, written application for Medicaid or the Request for Assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf. The application may be received by mail, fax, or hand delivery. The date of delivery to the agency must be stamped on the application. If an application is received after the agency’s business hours, the date of the application is the next business day.

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to complete an Application for Benefits in order to request a medically needy evaluation. If the Application for Benefits is submitted within 10 days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

M0120.600 When An Application Is Required

A. New Application Required

A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.
**B. Application NOT Required**

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. Changes in the enrollee’s circumstances do not require a new application. Changes that do not require a new application include, but are not limited to, the following:

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.
Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

<table>
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<th>DATE OF BIRTH:</th>
<th>PLACE OF BIRTH:</th>
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| U. S. CITIZEN? | YES | NO | IF NO, ALIEN NUMBER: |

| DO YOU RECEIVE SSI? | YES | NO | ARE YOU PREGNANT? | YES | NO | DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? | YES | NO |

| DO YOU HAVE HEALTH INSURANCE? | YES | NO | IF YES, COMPANY NAME: |
| POLICY #: | EFFECTIVE DATE: | TYPE OF COVERAGE: |

| DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? | YES | NO | IF YES, LIST MONTHS: |

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

<table>
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<table>
<thead>
<tr>
<th>SIGNATURE OF BCCEDP CASE MANAGER:</th>
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032-03-384/1
YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:

I have the right to:
♦ Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
♦ Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services or be notified of the reason for any delay.
♦ Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:
♦ Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
♦ Report any changes in information provided on this form within 10 days to my local department of social services.
♦ Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:
♦ This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
♦ The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
♦ The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
♦ Each provider of medical services may release any medical records pertaining to any services received by me.
♦ I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

________________________________________________ ______________________
Signature or Mark          Date
___________________________________________________  ______________________
Witness/Authorized Representative        Date

VOTER REGISTRATION

Check one of the following:
( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

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. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.
# TABLE OF CONTENTS

## M01 MEDICAID APPLICATION

### M0130.000 Application Processing

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processing Time Standards</td>
<td>1</td>
</tr>
<tr>
<td>Required Information and Verifications</td>
<td>3</td>
</tr>
<tr>
<td>Eligibility Determination Process</td>
<td>8</td>
</tr>
<tr>
<td>Applications Denied Under</td>
<td>10</td>
</tr>
<tr>
<td>Special Circumstances</td>
<td></td>
</tr>
</tbody>
</table>
M0130.100 Processing Time Standards

A. General Principle

Agencies are required by the State Plan to adhere to prescribed standards for the processing of medical assistance (Medicaid and FAMIS/FAMIS MOMS) applications. The amount of time allowed to process an application is based on the covered group under which the application must be evaluated.

B. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

   a. Pregnant Women

   Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application form.

   If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the Medicaid eligibility of the pregnant woman within the working 10 days.

   The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) on the 10th day. The NOA must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

   Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the NOA must state that the application is still pending.

   If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

   b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

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

   BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.
If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency’s receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a NOA on the 10th day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

2. **45/90 Day Requirement**

   Applications, including requests for retroactive coverage, must be processed within 45 days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination. For individuals who must receive a disability determination, the time standard is 90 days.

   The time standard begins with the date of receipt of a signed application and ends with the date of enrollment or the date the notification of denial of Medicaid is mailed to the applicant. The applicant must be informed of the agency's time standards.

   The eligibility worker must allow at least 10 days to receive the necessary verifications. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

3. **Processing Priority**

   Application processing priority must be given to applicants who are in need of Medicaid coverage for nursing facility or community-based long-term care, hospice care, or who are in emergent need of other covered services. These applications must be processed as quickly as possible.

4. **Time Standard Exceptions**

   The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

   - the applicant's inability to furnish necessary information for a reason beyond his/her control,
   - a delay in receipt of information from an examining physician,
   - a delay in the disability determination process,
   - a delay in receiving DMAS decision on property transfer undue hardship claim, or
   - an administrative or other emergency beyond the agency's control.

   If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.
When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

C. Application for Retroactive Coverage

When an applicant for Medicaid or other medical assistance reports that he, or anyone for whom he requests assistance, received a medical service within the three months prior to application, retroactive Medicaid eligibility must be determined. If the applicant reports receiving a hospital service within the 30 days prior to the application date, eligibility for SLH must be determined if the individual is not eligible for Medicaid.

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the three months prior to the application month. The applicant must provide all verifications necessary to determine eligibility during that period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi).

Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number (SSN) or a statement that the individual applied for the SSN, and date of birth.

1. Name

The name entered in the official case record and computer enrollment systems for each individual applicant must match the individual’s name on his Social
Security card or Social Security Administration (SSA) record verification. If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and MMIS computer systems.

For purposes of the case record only, the agency may choose to set up the case in the individual’s alleged name before it is changed on the Social Security card.

2. SSN

The SSN of an individual for whom Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA.

B. Required Verifications

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information. 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 verifications must be documented in the case record.

1. Exception - Newborns of Emergency Services Aliens

Newborn children born to emergency services alien women, who are determined eligible for Medicaid payment of emergency services only, must have an application filed on their behalf. The newborn’s mother must be determined eligible for and enrolled in Medicaid effective the date of the child’s birth. Eligibility verifications for the newborn are postponed until after initial enrollment.

NOTE: the postponement of verifications does NOT apply to processing the emergency services alien mother’s eligibility for Medicaid payment of her labor and delivery services.

a. Initial Enrollment

To initially enroll the newborn in Medicaid:

- a valid application must be filed for the newborn child;

- all verifications necessary to determine the mother’s Medicaid eligibility must be received;

- the mother must be determined eligible for and enrolled in Medicaid effective the date of the child’s birth (or earlier);

- if the reported countable income for the newborn child is less than or equal to 133% of the federal poverty level (FPL), enroll the newborn child in:
• AC 091 if the reported countable income appears to be less than or equal to 100% FPL, or

• AC 090 if the reported countable income appears to be over 100% FPL.

• If the reported countable income for the newborn child is OVER 133% of the FPL, do NOT enroll the child until all necessary verifications and documents are received for the child AND the child is determined eligible for Medicaid.

b. Follow-up Action After Initial Enrollment

The worker must complete follow-up actions after initially enrolling the newborn. See section M1510.300 for the worker’s follow-up responsibilities.

2. Copy Verification Documents

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies. It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

3. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied or the coverage cancelled due to the inability to determine eligibility.

C. Verification of Nonfinancial Eligibility Requirements

The applicant’s statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant’s statements:

1. Verification Not Required

• Virginia state residency,
• application for other benefits,
• institutional status,
• age for children under age 19,
• health insurance information (see sections F and G below), and
• dependent child information for individuals applying as parents or the caretaker-relative of a dependent child.

2. Verification Required

The following information must be verified:

• citizenship and identity;
• Social Security number (see section D below);
• legal presence in the U.S. of applicants age 19 or older;
• age of applicants age 65 and older;
• disability and blindness; and
• pregnancy.
See item E. below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age, disability and pregnancy.

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

1. Exceptions

• Children under age one born to Medicaid-eligible mothers (except newborns of emergency services alien mothers) are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met, as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together. A child eligible in this covered group does not need a Social Security number.

• Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

2. SSN Not Yet Issued

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration Office (SSA). An Enumeration Referral Form, form #032-03-400, available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi must be completed by the applicant. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not eligible in a child under 1 covered group, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

When entering the individual in ADAPT or MedPend, use the date the individual applied for an SSN, or the individual’s date of birth, preceded by “APP” as the individual’s SSN. For example, an individual applied for an SSN on October 13, 2006, enter “APP101306” as the individual’s SSN. If entering the individual directly in MMIS, use the date the individual applied for an SSN, or the individual’s date of birth, preceded by “888” as the individual’s SSN. For example, an individual applied for an SSN on October 13, 2006, enter “888101306” as the individual’s SSN.

E. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based
waivers) are exempt from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.** An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

1. **Documents That Demonstrate Legal Presence**
   An applicant may demonstrate legal presence by presenting one of the following documents:
   - valid evidence of U.S. citizenship;
   - valid evidence of legal permanent resident status;
   - valid evidence of conditional resident alien status;
   - a valid SSN verified by SSA;
   - a U.S. non-immigrant visa;
   - a pending or approved application for legal asylum;
   - a refugee or temporary protected status document; or
   - a pending application for an adjustment of residence status.

2. **Failure to Provide Proof of Legal Presence**
   An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:
   - a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
   - indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant’s receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

   The affidavit form is on the intranet at: [http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi](http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi).

   NOTE: The individual’s address on the affidavit form must be the individual’s **residence** address, not the mailing address.

3. **Relationship to Other Medicaid Requirements**
   Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200 D. does **NOT** meet the SSN requirement.

4. **Third Party Liability (TPL)**
   Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.
In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

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

G. Health Insurance Payment Program (HIPP)

If a member of the assistance unit is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan the HIPP Application and Medical History Questionnaire must be completed by the applicant. The Insurance Verification Form must be given to the applicant/recipient for completion by the employer (see M0290).

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

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

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the State Verification Exchange System (SVES) or State Online Query-Internet system (SOLQ-I) cannot be used. If the SDX system is used to verify benefits, the case record must be documented to show why SVES or SOLQ-I was not used.

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

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

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

The evaluation of eligibility requirements must be documented in writing. The ADAPT Verification Form (#032-03-366) or the Evaluation of Eligibility (form #032-03-823) may be used. The forms are available online at http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi.

Agency-created evaluation forms are acceptable as long as all information needed to determine eligibility is documented in ADAPT or on the evaluation form.
Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the general principles of Medicaid Eligibility determination.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering partial coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant’s Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

2. Enrollment

Medicaid cases must be enrolled in the Medicaid Management Information System (MMIS). Effective June 16, 2003, a new MMIS system was implemented. The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the current MMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:

- The program designation (PD) is now known as aid category (AC). The AC is now the former PD prefaced by the digit “0.” (e.g. AC 051).
- Coverage types are no longer used to enroll limited periods of coverage. Coverage is determined by begin and end dates.
- The former cancel reasons are now prefaced by the digit “0” (e.g. cancel reason 007).

When enrolling an individual in the MMIS, the appropriate aid category (AC) for the applicant’s covered group must be used. Enrollment procedures
and a list of ACs are found in the MMIS Users’ Guide for DSS, that can be accessed from the DSS local agency intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/vammis_documents.cgi.

3. Notification to Applicant

The Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) must be used to notify the applicant when:

- the application has been approved, including the effective date(s) of his Medicaid coverage;
- the retroactive Medicaid coverage was approved, including the effective dates;
- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy;
- there is a reason for delay in processing his application;
- a request for re-evaluation of an application in spenddown status has been completed; and
- a child has been approved or denied (including the specific reason for denial cited from policy) for FAMIS (see M21).

A copy of the notice must also be mailed to the individual who has applied on behalf of the applicant.

E. Notification for Retroactive Entitlement

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one NOA is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request must be written and documented in the record. When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid.
An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement specifically indicating the wish to withdraw the retroactive coverage part of the application.

C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

D. Duplicate Applications

Applications received requesting Medicaid and/or FAMIS for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A Notice of Action on Medicaid will be sent to the applicant when a duplicate application is denied.
# TABLE OF CONTENTS

## M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

### M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Principles</td>
<td>M0220.001</td>
</tr>
<tr>
<td>Citizenship and Naturalization</td>
<td>M0220.100</td>
</tr>
<tr>
<td>Alien Immigration Status</td>
<td>M0220.200</td>
</tr>
<tr>
<td>Immigration Status Verification</td>
<td>M0220.201</td>
</tr>
<tr>
<td>Systematic Alien Verification for Entitlements (SAVE)</td>
<td>M0220.202</td>
</tr>
<tr>
<td>Full Benefit Aliens</td>
<td>M0220.300</td>
</tr>
<tr>
<td>Aliens Receiving SSI</td>
<td>M0220.305</td>
</tr>
<tr>
<td>Certain American Indians</td>
<td>M0220.306</td>
</tr>
<tr>
<td>Qualified Aliens Defined</td>
<td>M0220.310</td>
</tr>
<tr>
<td>Veteran &amp; Active Military Aliens</td>
<td>M0220.311</td>
</tr>
<tr>
<td>Qualified Aliens Who Entered U.S. Before 8-22-96</td>
<td>M0220.312</td>
</tr>
<tr>
<td>Qualified Aliens Who Entered U.S. On/After 8-22-96</td>
<td>M0220.313</td>
</tr>
<tr>
<td>Grandfathered Aliens</td>
<td>M0220.314</td>
</tr>
<tr>
<td>Emergency Services Aliens</td>
<td>M0220.400</td>
</tr>
<tr>
<td>Unqualified Aliens</td>
<td>M0220.410</td>
</tr>
<tr>
<td>Qualified Aliens Who Entered U.S. On/After 8-22-96</td>
<td>M0220.411</td>
</tr>
<tr>
<td>Aliens Eligibility Requirements</td>
<td>M0220.500</td>
</tr>
<tr>
<td>Full Benefit Aliens Entitlement &amp; Enrollment</td>
<td>M0220.600</td>
</tr>
<tr>
<td>Emergency Services Aliens Entitlement &amp; Enrollment</td>
<td>M0220.700</td>
</tr>
</tbody>
</table>

## Appendices

- United States Citizenship and Immigration Services (USCIS) Offices .......................... Appendix 1 .......... 1
- Document Verification Request (Form G-845) ......................................................... Appendix 2 .......... 1
- Document Verification Request Supplement (Form G-845 Supplement) .................. Appendix 2a .......... 1
- Alien Codes Chart ................................................................................................. Appendix 3 .......... 1
- Emergency Medical Certification (Form 032-03-628) .......................................... Appendix 4 .......... 1
- Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking ........................................ Appendix 5 .......... 1
- SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents .................................................. Appendix 6 .......... 1
- Proof of U.S. Citizenship and Identity for Medicaid .................................................. Appendix 7 .......... 1
M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

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

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

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

B. Declaration of Citizenship/Alien Status

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

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

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

C. Procedures

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

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

A. Introduction

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

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

Title IV-E children who apply for or receive Medicaid must have in their case record a declaration of citizenship or qualified immigration status AND documentary evidence of the children’s citizenship or declared qualified immigration status. Title IV-E eligible children do NOT have to verify identity.

EXCEPTION 1: this policy does not apply to newborns who meet the Medically Indigent (MI) Newborn Children in section M0320.301 or Medically Needy (MN) Newborn Children in section M0330.302, covered groups because a Medicaid application is not required for these newborns. 

EXCEPTION 2: this policy does not apply to Medicare beneficiaries and SSI recipients, including former SSI recipients, if the local department of social services (LDSS) has verification from the Social Security Administration (such as a SVES response) of the individual’s Medicare enrollment and/or current or former SSI entitlement.

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

B. Procedures

1. Individual Born in the U.S.

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

A child born to an emergency services alien mother, who is eligible only for Medicaid payment of her labor and delivery services, must have a valid application filed in order to be enrolled in Medicaid. Once a valid application is obtained, the child may be enrolled prior to obtaining documentation of citizenship and identity. See section M0130.200 B for detailed policy and procedures.

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

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

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

b. Individual Born to Naturalized Parents

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

c. Naturalized Individual

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

3. Verification Required One Time

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

C. Documents Establishing U.S. Citizenship and Identity

1. Citizenship Document

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

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

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

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

2. Identity Document

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

3. Acceptable Documents

All documents must be either originals or copies certified by the issuing agency. Photocopies of original documents, including notarized copies are not acceptable.
Exception: A copy of a Virginia birth certificate that is in the existing LDSS agency record, or is presented by an individual as verification, is acceptable temporarily while the LDSS agency is waiting for certification of the copy as a true copy by the Virginia Department of Health (VDH). The agency may approve or renew coverage if the individual meets all other eligibility requirements.

The agency must obtain certification of the copy by VDH, and the certified copy must be placed in the record when received. The procedures for obtaining VDH certification are contained in the Citizenship and Identity Verification Procedures document posted on the LDSS Intranet. Acceptance of a photocopied birth certificate does not apply to individuals born outside of Virginia or for documentation of an individual’s identity.

4. Levels of Acceptable Documents

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

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

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

See the Level 2 section (subsection 6) for documents that prove citizenship by collective naturalization.

See M0220, Appendix 10 for information about the documents, the document issuer, and contact information for each document.

5. How to Verify Citizenship and Identity

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

6. How to Verify Citizenship

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

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

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

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

7. **How to Verify Identity**

If the individual presents the original of one of the documents in Levels 2, 3, or 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity, which includes a written affidavit for a child under age 16 if an affidavit was not used to prove the child’s citizenship. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf.

**NOTE:** An affidavit of identity for a child under 16 cannot be used if an affidavit was used to verify the child’s citizenship. An affidavit of identity cannot be used for an individual age 16 or older. If the applicant is age 16 or older, the agency must assist the applicant in obtaining an identity document.

If the individual does not present one of the documents in Chart 5 to verify identity, he is not eligible for Medicaid because he has failed to provide documentary evidence of identity. **See section E below before denying or cancelling Medicaid because of failure to verify identity.**

D. **Hierarchy of Documentation**

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

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

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

1. **LEVEL 1 – Primary Documents to Establish Both U.S. Citizenship and Identity**

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

**NOTE:** Persons born in American Samoa (including Swain's Island) are generally U.S. non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals.
NOTE: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by U.S. Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

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

<table>
<thead>
<tr>
<th>LEVEL 1 – Primary Documents</th>
<th>Explanation – Level 1</th>
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</thead>
<tbody>
<tr>
<td>* U.S. Passport</td>
<td>The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Note: Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</td>
</tr>
<tr>
<td>* Certificate of Naturalization (N-550 or N-570)</td>
<td>Department of Homeland Security issues this document for naturalization. NOTE: A Certificate of Naturalization may not have a number on it. Form numbers N-550 and N-570 are no longer used. DHS now uses form number N-565. The application form for naturalization is now N-400.</td>
</tr>
<tr>
<td>* Certificate of Citizenship (N-560 or N-561)</td>
<td>Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.</td>
</tr>
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</table>

2. LEVEL 2 - Secondary Documents to Establish U.S. Citizenship

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

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

NOTE: Applicants or recipients born outside the U.S. must submit a document listed under primary evidence of U.S. citizenship.
<table>
<thead>
<tr>
<th>LEVEL 2 – Secondary Documents</th>
<th>Explanation – Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A U.S. public birth record</td>
<td>A U.S. public birth record showing birth in:</td>
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<tr>
<td></td>
<td>• one of the 50 U.S. states;</td>
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<td></td>
<td>• District of Columbia;</td>
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<td></td>
<td>• *Puerto Rico (if born on or after January 13, 1941);</td>
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<td></td>
<td>• Guam (on or after April 10, 1899).</td>
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<td></td>
<td>• *Virgin Islands of the U.S. (on or after January 17, 1917);</td>
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<td></td>
<td>• American Samoa;</td>
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<td></td>
<td>• Swain's Island; or</td>
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<td></td>
<td>*Northern Mariana Islands (after November 4, 1986 (NMI local time)).</td>
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<td></td>
<td>The birth record document may be issued by the State, Commonwealth, Territory or local jurisdiction. It must have been issued before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship.</td>
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</table>

NOTE: Individuals born to foreign diplomats residing in one of the states, the District of Columbia, Puerto Rico, Guam or the Virgin Islands are not citizens of the United States.

If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish U.S. citizenship for collectively naturalized citizens:

a. Puerto Rico:

1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or

2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

b. U.S. Virgin Islands:

1) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or
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<thead>
<tr>
<th>LEVEL 2 – Secondary Documents</th>
<th>Explanation – Level 2</th>
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<tbody>
<tr>
<td>A U.S. public birth record</td>
<td>2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or</td>
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<tr>
<td></td>
<td>3) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.</td>
</tr>
<tr>
<td>c. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI))</td>
<td>1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or</td>
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<tr>
<td></td>
<td>2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or</td>
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<td></td>
<td>3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).</td>
</tr>
<tr>
<td></td>
<td>4) NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.</td>
</tr>
<tr>
<td>*Certification of Report of Birth (DS-1350)</td>
<td>The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.</td>
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<tr>
<td>LEVEL 2 – Secondary Documents</td>
<td>Explanation – Level 2</td>
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<tr>
<td>*Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)</td>
<td>The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.</td>
</tr>
<tr>
<td>*Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350)</td>
<td>Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.</td>
</tr>
<tr>
<td>U.S. Citizen Identification Card</td>
<td>(This form was issued as Form I-197 until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act. Note that section 1903(x) of the Act incorrectly refers to the same document as an I-97). INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.</td>
</tr>
<tr>
<td>Northern Mariana Card (I-873)</td>
<td>Issued by the DHS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986. The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.</td>
</tr>
<tr>
<td>American Indian Card (I-872)</td>
<td>Issued by DNS to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code &quot;KIC&quot; and a statement on the back denote U.S. citizenship.</td>
</tr>
<tr>
<td>Final adoption decree showing the child's name and a U.S. place of birth</td>
<td>The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.</td>
</tr>
<tr>
<td>Evidence of civil service employment by the U.S. government</td>
<td>The document must show employment by the U.S. government before June 1, 1976.</td>
</tr>
<tr>
<td>Official Military record of service</td>
<td>The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).</td>
</tr>
</tbody>
</table>
3. LEVEL 3 – Third Level Documents to Establish U.S. Citizenship

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

- primary evidence cannot be obtained within the State's reasonable opportunity period (see reasonable opportunity discussion below),
- secondary evidence does not exist or cannot be obtained, and
- the applicant or recipient alleges being born in the U.S.

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

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

<table>
<thead>
<tr>
<th>LEVEL 3 - Third Level Documents</th>
<th>Explanation – Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extract of hospital record on hospital letterhead established at the time of the person’s birth that was created 5 years before application and indicates a U.S. place of birth</td>
<td>(For children under 16 the document must have been created near the time of birth or 5 years before the date of application). An extract of a hospital record on hospital letterhead that was established at the time of the person's birth, that was created at least 5 years before the initial Medicaid application date and that indicates a U.S. place of birth is acceptable. Do not accept a birth certificate “souvenir” issued by the hospital. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.</td>
</tr>
<tr>
<td>Life or health or other insurance record that was created at least 5 years before the initial Medicaid application date and that indicates a U.S. place of birth</td>
<td>Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth and it was created at least 5 years before the initial Medicaid application date.</td>
</tr>
</tbody>
</table>

4. LEVEL 4 - Fourth Level Documents

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

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

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

<table>
<thead>
<tr>
<th>LEVEL 4 - Fourth Level Documents</th>
<th>Explanation – Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950).</td>
<td>The census record must also show the applicant's age.</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or agency should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion &quot;U.S. citizenship data requested.&quot; Add that the purpose is for Medicaid eligibility. This form requires a fee.</td>
<td></td>
</tr>
<tr>
<td>One of the documents listed that was created at least 5 years before the application for Medicaid</td>
<td>This document must be one of the following and show a U.S. place of birth:</td>
</tr>
<tr>
<td>• Seneca Indian tribal census record,</td>
<td></td>
</tr>
<tr>
<td>• Bureau of Indian Affairs tribal census records of the Navaho Indians,</td>
<td></td>
</tr>
<tr>
<td>• U.S. State Vital Statistics official notification of birth registration,</td>
<td></td>
</tr>
<tr>
<td>• An amended U.S. public birth record that is amended more than 5 years after the person's birth, or</td>
<td></td>
</tr>
<tr>
<td>• Statement signed by the physician or midwife who was in attendance at the time of birth.</td>
<td></td>
</tr>
<tr>
<td>Institutional admission papers from a nursing home, skilled nursing care facility or other institution</td>
<td>Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. There is no requirement that the institutional record be established a particular length of time before the Medicaid application date.</td>
</tr>
<tr>
<td>Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date and indicates a U.S. place of birth.</td>
<td>(For children under 16 the document must have been created near the time of birth or 5 years before the date of Medicaid application). Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.</td>
</tr>
<tr>
<td>LEVEL 4 - Fourth Level Documents</td>
<td>Explanation – Level 4</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>
| Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date and indicates a U.S. place of birth. | NOTE: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship. 

NOTE: For children under 16 the document must have been created near the time of birth or 5 years before the date of Medicaid application. |

<table>
<thead>
<tr>
<th>Written affidavit of citizenship</th>
<th>Affidavits should ONLY be used in rare circumstances. If the citizenship documentation requirement needs to be met through affidavits, the following rules apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.</td>
</tr>
<tr>
<td></td>
<td>• At least one of the individuals making the affidavit cannot be related to the applicant/recipient. Neither of the two individuals can be the applicant/recipient.</td>
</tr>
<tr>
<td></td>
<td>• <strong>In order for the affidavits to be acceptable, the persons making the affidavits must be able to provide proof of their own citizenship and identity.</strong></td>
</tr>
<tr>
<td></td>
<td>• If the individuals making the affidavits have information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit <strong>must</strong> contain this information as well.</td>
</tr>
<tr>
<td></td>
<td>• The agency must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (or guardian or representative) explaining why the evidence does not exist or cannot be readily obtained.</td>
</tr>
<tr>
<td></td>
<td>• The affidavits must be signed under penalty of perjury by the persons making the affidavits.</td>
</tr>
</tbody>
</table>

The Affidavit of Citizenship On Behalf Of Medicaid Applicants and Recipients, to be used by the two persons attesting to the applicant/recipient’s citizenship, is available on the intranet at: 
**http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0280-00-eng.doc**. 

The Affidavit of Citizenship By Medicaid Applicants and Recipients, to be used by the applicant/recipient or his guardian or authorized representative, is available on the intranet at: 
**http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0281-00-eng.doc**.

5. **CHART 5 - Evidence of Identity**

Section 1903 (x) of the Act provides that identity must be established. When Level 1 primary evidence of citizenship is not available, a document from the Level 2, Level 3 or Level 4 tables above may be presented if accompanied by an identity document from the following Chart 5 Identity Documents table.
The identity documents do not have a hierarchy of reliability. For applications or renewals that include children under age 16, the LDSS workers can send an Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 with the application or renewal forms.

CHART 5 – Identity Documents

<table>
<thead>
<tr>
<th>Identity Document</th>
<th>Explanation – Chart 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver’s license</td>
<td>A driver's license issued by State or Territory either with a photograph of the individual, or other identifying information such as name, age, sex, race, height, weight or eye color, is acceptable.</td>
</tr>
<tr>
<td>School identification card</td>
<td>A school identification card with the name and photograph of the individual is acceptable. The school ID card must be an official ID card issued by the school; unofficial ID cards such as those provided as a courtesy with school photographs, are not acceptable.</td>
</tr>
<tr>
<td>U.S. military card or draft record</td>
<td>U.S. military card or draft record is acceptable.</td>
</tr>
<tr>
<td>Identification card issued by the Federal, State, or local government</td>
<td>An identification card issued by the Federal, State, or local government with the same information included on driver's licenses is acceptable. At a minimum, the ID must have the individual’s name, address and photo. For photo ID cards, the photo must have been affixed to the ID card by the government agency that issued it. ID cards issued by a government agency that just have a space for the individual to attach a photo are NOT acceptable.</td>
</tr>
<tr>
<td>Military dependent's ID card</td>
<td>A military dependent's identification card is acceptable.</td>
</tr>
<tr>
<td>Native American Tribal document</td>
<td>A Native American Tribal document is acceptable.</td>
</tr>
<tr>
<td>U.S. Coast Guard Merchant Mariner card</td>
<td>A U.S. Coast Guard Merchant Mariner card is acceptable.</td>
</tr>
<tr>
<td>Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document</td>
<td>A Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document with a photograph or other personal identifying information relating to the individual is acceptable.</td>
</tr>
<tr>
<td>State Agency Computer Data</td>
<td>Identifying information from a Virginia state governmental data system can be used to provide identity verification for applicants and recipients. A copy of the screen(s) from a state data system that shows the individual’s name, DOB, gender and SSN is acceptable documentation of the individual’s identity if the agency establishes the true identity of the individual.</td>
</tr>
<tr>
<td>Special identity rules for children under age 16</td>
<td>For children under 16, school records may include nursery or child care records. The school, nursery or daycare record must contain the child’s name, date of birth, place of birth and the parents’ names. The form agencies should use to request the school, nursery or daycare</td>
</tr>
</tbody>
</table>
Special identity rules for children under age 16

record is posted on the intranet. The school record request form workers can give to a child’s parent or guardian to give to the school is posted to the intranet at http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi.

a. Foster Care Children

The Child Protective Services’ (CPS) notarized affidavit that is attached to the court petition requesting custody of the child is an acceptable identity verification document. Place a copy of the CPS affidavit in the child’s Medicaid case record. A copy of the Online Automated Services Information System (OASIS) screen that contains the child’s name, date of birth, gender and race is acceptable as identity verification for a foster care child and should be placed in the child’s Medicaid case record if used as verification of identity.

b. Written affidavit of identity

For children under 16 only, an affidavit of identity may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided for the child. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is available on the LDSS Intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf and may be sent to the parent with the application or renewal form when the agency is aware that a child under age 16 is in the home.

The Application for Health Insurance for Children and Pregnant Women (FAMIS 1) and the Medicaid Renewal form (#032-03-0669) available on the LDSS Intranet contain an area for the parent to attest to the identity of a child under age 16. A separate affidavit of identity is not necessary when the parent has attested to identity on the application or renewal form.

D. Agency Action

1. Documentation From Case Record and Individual

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

   • Existing LDSS agency records as long as the documentation conforms to Medicaid policy for citizenship and identity verification in M0220 of the Medicaid Eligibility Manual.

   • Applicants and Recipients. All applicants and recipients, except SSI recipients and Medicare beneficiaries, must provide documents that show proof of U.S. citizenship and proof of the person’s identity. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.
Original documents may be viewed by all eligibility, administrative, and services staff of the LDSS as long as the person viewing the document makes a copy of the document, notes that the original was viewed, and signs and dates the copy.

2. **Authorized Representative**

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

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

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

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

3. **Documents From Other Approved Organizations**

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

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

DMAS has approved documentation copies from the following:

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

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

Hospital contractors, such as Chamberlin-Edmonds, are not considered authorized to view original documents.
4. **DMAS FAMIS Plus Unit**

Original documents can be viewed by local department of social services (LDSS) for applications handled by the Department of Medical Assistance Services (DMAS) FAMIS Plus Unit. As a service to clients, staff from any LDSS is to view an original document, make a copy, and note on the copy that the original was viewed, including the date and signature of the staff person. The LDSS are to send or fax the annotated copy to the DMAS FAMIS Plus Unit. The DMAS FAMIS Plus Unit will accept the copy and place it in the record. This process will significantly reduce the likelihood of important and possibly irreplaceable documents being misplaced or destroyed.

5. **SSI Recipients and Medicare Beneficiaries**

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

6. **Individual NOT Required to Submit Documents in Person**

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

_for individuals who need assistance securing a birth certificate, LDSS may request birth certificate verification from the Virginia Department of Health (VDH) without receiving additional approval from the recipient beyond the recipient’s original signature on the individual’s application for Medicaid. If VDH is unable to produce birth certificate verification, however, the individual is to be notified that documentation of citizenship is needed and allowed the reasonable opportunity period to secure the documentation (see M0220.100 D.8 below)._
The "reasonable opportunity period" permits exceptions from the standard time limits for processing applications when an applicant or recipient in good faith tries to present documentation, but is unable to do so because the documents are not available. In such cases, the agency should extend the application processing time limit and assist the individual in securing evidence of citizenship and/or identity.

If the individual cannot readily or easily produce citizenship documentation or it is a hardship to secure that documentation, secure the documentation for the individual using the process contained in the “Citizenship and Identity Verification Procedures” document posted on the VDSS Intranet for contact with the Virginia Department of Health for birth certificate documentation.

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

b. Extending the Processing Time Frames

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

- An extension of 30 calendar days may be granted when the applicant/recipient has requested, but not received the required documents, or requested assistance in obtaining documents.

- An additional extension of up to 10 working days may be granted at the end of the 30-day extension when there is documentation that the information has been requested, but has not been received.

If the required information has not been received by the end of the extensions, appropriate action to deny or cancel coverage must be taken.

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

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

9. Failure to Provide Requested Verifications

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

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

10. Denial or Cancellation Action

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

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

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

11. Notification Requirements

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

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

12. Maintain Documents in Case Record

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

13. Reporting Requirements

Each month, agencies will report information regarding denials of eligibility to ABD and/or Long-term Care applicants when one of the reasons, or the only reason, for the action was due to failure to verify citizenship or identity. (A system-generated report became available on 12-01-2006 that reports F&C denials entered in ADAPT, so agencies no longer have to report these denials manually). To report ABD and LTC denials, use the EXCEL spreadsheet on the VDSS local agency intranet at http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/medicaiddeniedcanceled.xls.

Email the monthly report by the 10th of the following month to the Medical Assistance Unit, Division of Benefit Programs, staff person named in the “Citizenship and Identity Verification Procedures” document posted on the local agency intranet. Email a copy of the report to the Medical Assistance Program Consultant assigned to the LDSS’ service area.
The Medical Assistance Program Consultants will also be conducting reviews of cases where Medicaid eligibility was denied or terminated because of lack of citizenship and/or identity verification.

14. Refer Cases of Suspected Fraud to DMAS

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

M0220.200 ALIEN IMMIGRATION STATUS

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

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

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 a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on form I-94.

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).

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

C. Letters that Verify Status

The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the 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 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.
b. Such aliens are provided Forms I-94 and/or I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.

11. Deferred Action Status

Aliens granted deferred action status pursuant to INS operating instructions.

a. Aliens in this group are similar to those under an order of supervision except there have been no formal deportation proceedings initiated.

b. Aliens in this group will have a Form I-210 or a letter indicating that the alien's departure has been deferred.

12. Deportation Suspended

Aliens granted suspension of deportation pursuant to section 244 of the INA (8 USC 1254) whose departure the INS does not contemplate enforcing.

a. Aliens in this group have been found deportable, have met a period of continuous residence and have filed an application for INS to suspend deportation in an effort to be granted lawful permanent resident status.

b. If the suspension is granted, the alien must wait through two full sessions of the Congress. If the Congress does not take action on the application, INS will grant the alien lawful permanent residence.

c. These aliens will have a letter/order from the immigration judge and a Form I-94 with employment authorized for 1 year. After lawful permanent residence is granted, the alien will have a Form I-551, or I-151.

M0220.400  EMERGENCY SERVICES ALIENS

A. Policy

Any alien who does NOT meet the requirements for full benefits as described in section M0220.300 through 314 above is an “emergency services” alien and is eligible for emergency Medicaid services only, if he or she meets all of the Medicaid nonfinancial and financial eligibility requirements.

B. Procedure

Section M0220.410 defines “unqualified” aliens.

Section M0220.411 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.

Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.

Section M0220.700 contains the entitlement and enrollment procedures for emergency services aliens.
M0220.410 UNQUALIFIED ALIENS

A. Unqualified Aliens

Aliens who do not meet the qualified alien definition M0220.310 above and who are NOT “grandfathered” aliens (M0220.314 above) are “unqualified” aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.

B. Illegal aliens

Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.

C. Non-immigrant Aliens

Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has not expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are usually not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). Non-immigrants have the following types of INS documentation:

- Form I-94 Arrival-Departure Record,
- Form I-185 Canadian Border Crossing Card,
- Form I-186 Mexican Border Crossing Card,
- Form SW-434 Mexican Border Visitor’s Permit,
- Form I-95A Crewman’s Landing Permit.

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

Non-immigrants include:

1. Visitors

visitors for business or pleasure, including exchange visitors;

2. Foreign Government Representative

foreign government representatives on official business and their families and servants;

3. Travel Status

aliens in travel status while traveling directly through the U.S.;

4. Crewmen

crewmen on shore leave;

5. Treaty Traders

treaty traders and investors and their families;

6. Foreign Students

foreign students;

7. International Organization

international organization representatives and personnel, and their families and servants;
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 M0220.500 B.2 below. *Note that the enrollment period for the emergency service(s) includes the day of discharge even though it is not counted to determine the length of stay (see M0220.700).*

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 an *emergency-services-only alien mother* is NOT entitled to Medicaid as a newborn child (see M320.301) or as a Child Under Age 1 (M330.302). *In order for the newborn child’s Medicaid eligibility to be determined, an application must be filed.*

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

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

**M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT**

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

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

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

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

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

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

2. CI
   In this field, Citizenship code, enter:
   
   \[ A = \text{Emergency services alien (Alien Chart codes B2, C2, C3, D2, D3, E2, E3, F3, G3, H3, I2, I3, codes J3 through V3) other than dialysis patient.}\]
   
   \[ D = \text{Emergency services alien who receives dialysis.}\]
   
   \[ V = \text{Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).}\]

The Alien Codes Chart is found in Appendix 3 to this subchapter.

**NOTE:** Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Medicaid Virginia state residency requirement.
3. Entry date
   **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. App Dt
   In this field, application date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. Covered Dates
   - Begin
     In this field, coverage begin date, enter the begin date of the emergency service(s).

6. Covered Dates
   - End
     In this field, coverage end date, enter the date when the alien's emergency service(s) ends. *When the emergency service(s) received was related to labor and delivery, the end date includes the day of discharge even though it is not counted to determine the length of stay for certification purposes.*

7. PD (AC)
   Enter the code applicable to the alien’s covered group.

D. Notices
   Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility.

   A Medicaid card will not be generated for an individual enrolled as an emergency services alien.

   The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628, Emergency Medical Certification, to the provider(s).
Proof of U.S. Citizenship and Identity for Medicaid

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

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

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

<table>
<thead>
<tr>
<th>Document</th>
<th>Shows Proof Of</th>
<th>Issued By</th>
<th>Fee</th>
<th>For More Information, Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Passport (unexpired or expired)</td>
<td>Citizenship &amp; Identity (if issued with limitation and expired, only shows proof of identity)</td>
<td>U.S. Department of State</td>
<td>Varies</td>
<td>(202) 647-4000 or <a href="http://www.state.gov">www.state.gov</a></td>
</tr>
<tr>
<td>Certificate of Citizenship (N5-560 or N-561)—issued when a person was born outside U.S. to U.S. Citizen parent(s)</td>
<td>Citizenship &amp; Identity</td>
<td>U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services</td>
<td>Varies</td>
<td>1-800-375-5283 or <a href="http://www.uscis.gov">www.uscis.gov</a></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Document</th>
<th>Shows Proof Of</th>
<th>Issued By</th>
<th>Fee</th>
<th>For More Information, Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Public Birth Record (“Birth Certificate”)—must contain original embossed seal</td>
<td>Citizenship—(Must also provide proof of identity)</td>
<td>The state, commonwealth, territory or local jurisdiction</td>
<td>Va. Birth Cert. $12</td>
<td>For citizens born in Virginia: Department of Health, Division of Vital Records: (804) 662-6200 or <a href="http://www.vdh.virginia.gov">www.vdh.virginia.gov</a> (will also assist citizens born outside Virginia with finding contact information for their birth state)</td>
</tr>
<tr>
<td>Document</td>
<td>Shows Proof Of</td>
<td>Issued By</td>
<td>Fee</td>
<td>For More Information, Contact</td>
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<tr>
<td>Certification of Report of Birth (FS-240); Consular Report of Birth Abroad of a Citizen of the U.S.A. (FS-545), Certification of Birth Abroad (FS-545)</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>U.S. Department of State</td>
<td>Varies</td>
<td>(202) 647-4000 or <a href="http://www.state.gov">www.state.gov</a></td>
</tr>
<tr>
<td>American Indian Card (I-872)</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services</td>
<td>Contact agency</td>
<td>1-800-375-5283 or <a href="http://www.uscis.gov">www.uscis.gov</a></td>
</tr>
<tr>
<td>Final adoption decree (or statement from state-approved adoption agency if adoption is not finalized) — must show child's name and U.S. place of birth</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>The state in which the adoption was finalized</td>
<td>Possible copying fee</td>
<td>The court issuing the decree or the adoption agency that handled the adoption</td>
</tr>
<tr>
<td>Evidence of Civil Services Employment by the U.S. Government—must show employment by the U.S. government before June 1, 1976</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>U.S. Office of Personnel Management</td>
<td>Possible copying fee</td>
<td>1-888-767-6738 or <a href="http://www.opm.gov">www.opm.gov</a></td>
</tr>
<tr>
<td>Official Military Record of Service—must show a U.S. place of birth (e.g. DD-214)</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>National Archives Allow 6-8 weeks</td>
<td>None</td>
<td>1-866-272-6272 or <a href="http://www.vetrecs.archives.gov">www.vetrecs.archives.gov</a></td>
</tr>
<tr>
<td>Extract of hospital record on hospital letterhead (not a &quot;birth certificate&quot; issued by a hospital) — must have been established at the time of birth, created at least 5 years before initial application date for Medicaid, and indicate a U.S. place of birth</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>Hospital of birth</td>
<td>Possible copying fee</td>
<td>Hospital in which individual was born</td>
</tr>
<tr>
<td>Life or health or other Insurance Record—must have been created at least 5 years before the initial application date for Medicaid and show a U.S. place of birth</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>Insurance Company</td>
<td>Possible copying fee</td>
<td>Insurance company that issued the policy—contact information should be listed on the policy</td>
</tr>
<tr>
<td>Document</td>
<td>Shows Proof Of</td>
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<td>Fee</td>
<td>For More Information, Contact</td>
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<tr>
<td>A statement signed by the physician or midwife who was in attendance at the time of the birth—must have been created at least 5 years before the date of the initial Medicaid application and show a U.S. place of birth.</td>
<td>Citizenship (Must also provide proof of identity)</td>
<td>Physician or Midwife who delivered the individual</td>
<td>Possible copying fee</td>
<td>Physician or Midwife</td>
</tr>
<tr>
<td>Institutional admission papers from a nursing home or other institution or medical records—must have been created at least 5 years before the date of the initial Medicaid application and indicate a U.S. place of birth</td>
<td>Nursing home or other institution in which the individual resides or resided</td>
<td>Possible copying fee</td>
<td>Nursing home or other institution</td>
<td></td>
</tr>
</tbody>
</table>

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

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

## M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

### M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM ABSENT PARENT REQUIREMENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Principles</td>
<td>1</td>
</tr>
<tr>
<td>Assignment of Rights</td>
<td>1</td>
</tr>
<tr>
<td>Procedures for Assignment of Rights</td>
<td>2</td>
</tr>
<tr>
<td>Pursuit of Medical Support From the Absent Parent</td>
<td>3</td>
</tr>
</tbody>
</table>
M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS

M0250.001 GENERAL PRINCIPLES

A. Introduction
The assignment of rights to medical support and the pursuit of support from absent parent(s) are Medicaid nonfinancial requirements that must be met as a condition of Medicaid eligibility.

B. Policy and Procedures
The policy and procedures for the local agency to follow in determining if an individual has met the Medicaid assignment of rights and pursuit of support from absent legally responsible relatives are contained in the following sections:

- M0250.100 Assignment of Rights.
- M0250.200 Procedures for the Assignment of Rights.
- M0250.300 Pursuit of Medical Support From the Absent Parent.

M0250.100 ASSIGNMENT OF RIGHTS

A. Assignment of Rights Policy
To be eligible for Medicaid, a Medicaid applicant or recipient must:

- assign his rights to medical support and payment for medical care from any third party to the Department of Medical Assistance Services (DMAS) if he is applying for himself;
- assign the rights of any other individual for whom he applies and can make an assignment of rights to support and third party payments;
- cooperate with the agency in identifying (to the extent he is able) potentially liable insurers and other third parties who may be liable to pay for the individual's, and any other individual for whom he applies and can assign rights for care and medical services.

B. Individual Unable To Assign Rights
If the individual is unable to assign rights, a spouse, legally appointed guardian or conservator, attorney-in-fact (person who has the individual’s power-of-attorney), or the authorized representative can make such an assignment. If the individual is a child, the parent, legal custodian, authorized representative, or the adult relative with whom the child lives and who signed the application can assign rights.

If the person who has the authority to assign the applicant’s/recipient’s rights refuses to assign the rights, the person who has the authority to assign the rights will be ineligible for Medicaid. However, the applicant/recipient will meet the assignment of rights requirement and can be eligible for Medicaid if he meets all other eligibility requirements.
M0250.200 PROCEDURES FOR ASSIGNMENT OF RIGHTS

A. Forms

The assignment of rights information is contained on the following application forms used for Medicaid:

- Application For Benefits (form #032-03-824),
- Application/Redetermination For Medical Assistance For SSI Recipients (form #032-03-091),
- An Application for Children’s Health Insurance in Virginia (form FAMIS – 1),
- Medicaid Application For Medically Indigent Pregnant Women (form #032-03-040), and
- the ADAPT Statement of Facts.

By signing the application for Medicaid, the individual assigns his/her own rights and the rights of anyone for whom the individual has applied and can assign rights.

B. Refusal To Assign Rights Or Cooperate

An individual who is able to assign rights but who refuses or fails to meet the assignment of rights requirements in this subchapter is not eligible for Medicaid. Deny or cancel Medicaid coverage to an individual who:

- refuses to assign his own rights if he applies for himself,
- refuses to assign the rights of any other applicant for whom he can make an assignment, or
- refuses to cooperate in identifying and providing liable third party information, unless cooperation has been waived for good cause.

C. Cooperation – Assignment of Rights

Cooperation in assisting the agency in securing medical support and payments includes requiring the individual to:

- provide identifying information about liable third parties, such as the liable person’s insurance company and policy number, the medical services covered by the insurance policy, etc.;
- appear as a witness at a court or other proceeding;
- provide information, or attest to lack of information, under penalty of perjury;
- pay to the agency any medical care funds received that are covered by the assignment of rights; and
• take any other reasonable steps to assist the state in pursuing any liable third party.

Should DMAS or the local agency request information from the individual, including information about third party liability, or otherwise require cooperation with the pursuit of medical support and/or third party liability as outlined in M0250.200 C. above, the individual must cooperate with the pursuit of medical support in order for the individual’s eligibility to continue.

1. Waiver of Cooperation

A waiver of the cooperation requirement in identifying and providing liable third party information is allowed if the agency finds that cooperation is against the best interests of the individual, or other person for whom he/she can assign rights, because the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the individual or other person.

2. Documentation

Document the case record with the reason(s) the individual refuses to cooperate in identifying and providing liable third party information and the reason(s) the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can assign rights.

M0250.300 PURSUIT OF MEDICAL SUPPORT FROM THE ABSENT PARENT

A. Policy

To be eligible for Medicaid, an individual applicant or recipient must cooperate with the agency in obtaining medical support and payments from, or derived from, the absent parent(s) of a child for whom the individual is applying, unless the individual establishes good cause for not cooperating.

B. Definition of Cooperation

1. Application

By signing the application for Medicaid, the individual meets the eligibility requirement to cooperate in pursuing support from the absent parent(s) of the child for whom the individual is applying. No further action by the applicant is required at the time of application.

The individual is not required to contact DCSE about pursuing support from the absent parent. If the individual chooses to request DCSE services, the individual’s continued cooperation with DCSE is not required for Medicaid eligibility.

2. Ongoing

After the individual’s application has been approved, if DMAS or the local agency requests information from the individual about the absent parent, or otherwise requires the individual’s cooperation with the pursuit of medical support from the absent parent, the individual must cooperate in order for the individual’s eligibility to continue.
C. Local DSS Agency Responsibility

Explain and offer the Division of Child Support Enforcement (DCSE) services to all Medicaid applicants who apply for Medicaid for themselves and/or on behalf of children who have an absent parent. A child’s parent is not considered absent if the absence is due to death, single parent adoption, artificial insemination, or termination of parental rights.

Give the applicant the DCSE Fact Sheet available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

D. DCSE

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s) and establishing paternity when the alleged father is absent from the home. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child (ren), and court action to secure support from the absent legally responsible parent.

The booklet, "Child Support and You", form #032-01-945, gives an overview of DCSE services and the addresses for the district offices.
# TABLE OF CONTENTS

## M03 COVERED GROUPS REQUIREMENTS

<table>
<thead>
<tr>
<th>SUBCHAPTER</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL RULES &amp; PROCEDURES</td>
<td>M0310.000</td>
</tr>
<tr>
<td>General Principles of Covered Groups</td>
<td>M0310.001</td>
</tr>
<tr>
<td>List of Medicaid Covered Groups</td>
<td>M0310.002</td>
</tr>
<tr>
<td>Definitions of Terms</td>
<td>M0310.003</td>
</tr>
<tr>
<td>Disability Report Adult</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>Disability Report Child</td>
<td>Appendix 2</td>
</tr>
<tr>
<td>Authorization for Source to Release Information</td>
<td></td>
</tr>
<tr>
<td>To the Social Security Administration</td>
<td>Appendix 3</td>
</tr>
<tr>
<td>Disability Determination Services Referral</td>
<td>Appendix 4</td>
</tr>
<tr>
<td>CATEGORICALLY NEEDY GROUPS</td>
<td>M0320.000</td>
</tr>
<tr>
<td>General Policy Principles</td>
<td>M0320.001</td>
</tr>
<tr>
<td>Protected Covered Groups</td>
<td>M0320.100</td>
</tr>
<tr>
<td>ABD Categorically Needy Groups</td>
<td>M0320.200</td>
</tr>
<tr>
<td>Families and Children Categorically Needy Groups</td>
<td>M0320.300</td>
</tr>
<tr>
<td>MEDICALLY NEEDY GROUPS</td>
<td>M0330.000</td>
</tr>
<tr>
<td>General Policy Principles</td>
<td>M0330.001</td>
</tr>
<tr>
<td>ABD Medically Needy Groups</td>
<td>M0330.200</td>
</tr>
<tr>
<td>Families and Children Medically Needy Groups</td>
<td>M0330.300</td>
</tr>
</tbody>
</table>
d. Hospice—a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.

2. F&C Groups

a. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBS.

b. Children under age 1 born on or after October 1, 1984, to mothers who were eligible for and receiving Medicaid as categorically needy or categorically needy non-money payment at the time of the child's birth.

c. Non-IV-E foster care or Juvenile Justice Department children, or non-IV-E adoption assistance children.

d. Individuals under age 21 in an ICF or ICF-MR.

e. F&C individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.

f. F&C individuals who receive or are applying for Medicaid-approved community-based care waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.

C. Medically Indigent (MI)

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MI classification are listed below.

1. ABD Groups

a. Qualified Medicare Beneficiaries (QMBs).

b. Special Low-income Medicare Beneficiaries (SLMBs).

c. Qualified Disabled and Working Individuals (QDWIs).

d. Qualified Individuals (QI) - Group I and Group 2 (QI-1 and QI-2).

e. ABD With Income ≤ 80% Federal Poverty Limit (ABD 80% FPL).

f. MEDICAID WORKS.
2. F&C Groups
   a. Pregnant women and newborns under age 1 year.
   
b. *Family Planning Services.*
   
c. *Children under age 19 years.*

   Women screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.

D. Medically Needy (MN)
   The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MN classification are listed below.

1. ABD Groups
   a. Aged - age 65 years or older.
   
b. Blind - meets the blind definition
   
c. Disabled - meets the disability definition.
   
d. Individuals who received Medicaid in December 1973 as AB/APTD-related medically needy and who continue to meet the December 1973 eligibility requirements.

2. F&C Groups
   a. Children under age 18.
   
b. Children under age 1.
   
c. Pregnant Women.
   
d. Non-IV-E Foster Care/Adoption Assistance children and Juvenile Justice Department children.
   
e. Individuals under age 21 in an ICF or ICF-MR.

E. Refugees
   “Refugees” are a special group of individuals who have an alien status of “refugee”, and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first 8 months they are in the U.S.

   There are two PDs for this group. PD 78 is used for Refugee Other and Refugee Medicaid Other and PD 79 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.
# TABLE OF CONTENTS

## M03 MEDICAID COVERED GROUPS

### M0320.000 CATEGORICALLY NEEDY GROUPS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Policy Principles</td>
<td>1</td>
</tr>
<tr>
<td>Protected Covered Groups</td>
<td>2</td>
</tr>
<tr>
<td>Former Money Payment Recipients</td>
<td>2</td>
</tr>
<tr>
<td>August 1972</td>
<td>2</td>
</tr>
<tr>
<td>Conversion Cases</td>
<td>4</td>
</tr>
<tr>
<td>Former SSI/AG Recipients</td>
<td>8</td>
</tr>
<tr>
<td>Protected Widows or Widowers</td>
<td>13</td>
</tr>
<tr>
<td>Qualified Severely Impaired Individuals (QSI)-1619(b)</td>
<td>18</td>
</tr>
<tr>
<td>Protected Adult Disabled Children</td>
<td>20</td>
</tr>
<tr>
<td>Protected SSI Disabled Children</td>
<td>22</td>
</tr>
<tr>
<td>ABD Categorically Needy Groups</td>
<td>22b</td>
</tr>
<tr>
<td>SSI Recipients</td>
<td>23</td>
</tr>
<tr>
<td>AG Recipients</td>
<td>25</td>
</tr>
<tr>
<td>ABD In Medical Institution, Income ≤ 300% SSI</td>
<td>26</td>
</tr>
<tr>
<td>ABD Receiving Waiver Services (CBC)</td>
<td>28</td>
</tr>
<tr>
<td>ABD Hospice</td>
<td>31</td>
</tr>
<tr>
<td>QMB (Qualified Medicare Beneficiary)</td>
<td>34</td>
</tr>
<tr>
<td>SLMB (Special Low-income Medicare Beneficiary)</td>
<td>38</td>
</tr>
<tr>
<td>QI (Qualified Individuals)</td>
<td>42</td>
</tr>
<tr>
<td>QDWI (Qualified Disabled &amp; Working Individual)</td>
<td>42e</td>
</tr>
<tr>
<td>ABD With Income ≤ 80% FPL</td>
<td>44</td>
</tr>
<tr>
<td>MEDICAID WORKS</td>
<td>45</td>
</tr>
<tr>
<td>Families &amp; Children Categorically Needy Groups</td>
<td>46e</td>
</tr>
<tr>
<td>MI Pregnant Women &amp; Newborn Children</td>
<td>46f</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>49</td>
</tr>
<tr>
<td>MI Child Under Age 19</td>
<td>50a</td>
</tr>
<tr>
<td>IV-E Foster Care or IV-E Adoption Assistance Recipients</td>
<td>51</td>
</tr>
<tr>
<td>Low Income Families With Children (LIFC)</td>
<td>52</td>
</tr>
<tr>
<td>Individuals Under Age 21</td>
<td>54</td>
</tr>
<tr>
<td>Special Medical Needs Adoption Assistance Children</td>
<td>58</td>
</tr>
<tr>
<td>F&amp;C In Medical Institution, Income ≤ 300% SSI</td>
<td>60</td>
</tr>
<tr>
<td>F&amp;C Receiving Waiver Services (CBC)</td>
<td>63</td>
</tr>
<tr>
<td>F&amp;C Hospice</td>
<td>66</td>
</tr>
<tr>
<td>Breast and Cervical Cancer Prevention Treatment Act</td>
<td>69</td>
</tr>
<tr>
<td>(BCCPTA)</td>
<td></td>
</tr>
</tbody>
</table>
A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals. Most of the CN groups are mandatory; some are optional which Virginia has chosen to cover in its Medicaid state plan.

Two of the Virginia Medicaid “subclassifications,” the “categorically needy non-money payment (CNNMP)” and the “medically indigent (MI),” are actually categorically needy covered groups according to the federal Medicaid law and regulations. This subchapter divides the covered groups which are classified as CN into “protected,” “ABD” and “F&C” groups.

Determine an individual’s eligibility first in a categorically needy covered group. If the individual is not eligible as categorically needy, go to the medically needy groups in subchapter M0330.

The following sections in this chapter contain the policy and procedures for determining whether an individual meets a Medicaid categorically needy covered group:

- M0320.100 Protected Covered Groups
- M0320.101 Former Money Payment Recipients August 1972
- M0320.102 Conversion Cases
- M0320.103 Former SSI/AG Recipients
- M0320.104 Protected Widows or Widowers
- M0320.105 Qualified Severely Impaired Individuals (QSII-1619(b))
- M0320.106 Protected Adult Disabled Children
- M0320.107 Protected SSI Disabled Children
- M0320.200 ABD Categorically Needy Groups
- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income ≤ 300% SSI
- M0320.204 ABD Receiving Waiver Services
- M0320.205 ABD Hospice
- M0320.206 QMB (Qualified Medicare Beneficiary)
- M0320.207 SLMB (Special Low-income Medicare Beneficiary)
- M0320.208 QI (Qualified Individuals)
- M0320.209 QDWI (Qualified Disabled & Working Individual)
- M0320.210 ABD With Income ≤ 80% FPL
- M0320.211 MEDICAID WORKS
- M0320.300 Families & Children Categorically Needy Groups
- M0320.301 MI Pregnant Women & Newborn Child
- M0320.302 Family Planning Services
- M0320.303 MI Child Under Age 19
- M0320.305 IV-E Foster Care or IV-E Adoption Assistance Recipients
- M0320.306 Low Income Families With Dependent Children (LIFC)
M0320.201 Former Money Payment Recipients August 1972

A. Policy

42 CFR 435.114 and 42 CFR 435.134 -- The agency must provide Medicaid to individuals who meet the following conditions:

1. Entitled to OASDI In August 1972 & Received Cash Assistance

   In August 1972, the individual was entitled to OASDI and

   - he was receiving AFDC, Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD); or
   - he would have been eligible for one of those programs if he had applied and the Medicaid plan covered this optional group. The Virginia plan covered this group; or
   - he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.

2. Would Currently Be Eligible If Increase Were Excluded

   The individual would meet the F&C income limits for LIFC or currently eligible for SSI or AG except that the increase in OASDI under P.L. 92-336 raised his income over the F&C income limits or SSI. This includes an individual who

   - meets all LIFC requirements or current SSI requirements except for the requirement to file an application; or
The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

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

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

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

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

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

3) for a blind or disabled child living with a parent, calculate the parent’s income (as determined by deeming procedures in chapter M05) and compare the child’s countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child’s parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

4. COLA Formula

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

\[
\begin{align*}
a. \quad \text{Current Title II Benefit} & = \quad \text{Benefit Before} \\ & \times 1.033 \quad (1/07 \text{ Increase}) \\ & \times 1/07 \text{ COLA} \\
b. \quad \text{Benefit Before 1/07 COLA} & = \quad \text{Benefit Before} \\ & \times 1.041 \quad (1/06 \text{ Increase}) \\ & \times 1/06 \text{ COLA} \\
c. \quad \text{Benefit Before 1/06 COLA} & = \quad \text{Benefit Before} \\ & \times 1.027 \quad (1/05 \text{ Increase}) \\ & \times 1/05 \text{ COLA} \\
d. \quad \text{Benefit Before 1/05 COLA} & = \quad \text{Benefit Before} \\ & \times 1.021 \quad (1/04 \text{ Increase}) \\ & \times 1/04 \text{ COLA} \\
e. \quad \text{Benefit Before 1/04 COLA} & = \quad \text{Benefit Before} \\ & \times 1.014 \quad (1/03 \text{ Increase}) \\ & \times 1/03 \text{ COLA} \\
f. \quad \text{Benefit Before 1/03 COLA} & = \quad \text{Benefit Before} \\ & \times 1.026 \quad (1/02 \text{ Increase}) \\ & \times 1/02 \text{ COLA}
\end{align*}
\]

Contact a Medical Assistance Program Specialist for amounts for years prior to 2002.

5. **Medicare Premiums**

   a. **Medicare Part B premium amounts:**

   \[
   \begin{align*}
   1-1-07 & \quad $93.50 \\
   1-1-06 & \quad $88.50 \\
   1-1-05 & \quad $78.20 \\
   1-1-04 & \quad $66.60 \\
   1-1-03 & \quad $58.70 \\
   1-1-02 & \quad $54.00
   \end{align*}
   \]

   b. **Medicare Part A premium amounts:**

   \[
   \begin{align*}
   1-1-07 & \quad $410.00 \\
   1-1-06 & \quad $393.00 \\
   1-1-05 & \quad $375.00 \\
   1-1-04 & \quad $343.00 \\
   1-1-03 & \quad $316.00 \\
   1-1-02 & \quad $319.00
   \end{align*}
   \]

Contact a Medical Assistance Program Specialist for amounts for years prior to 2002.

6. **Classification**

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

   Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.
M0320.201  SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipient are a mandatory CN covered group. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than SSI real property eligibility requirements. Thus, Virginia SSI recipients must apply separately for Medicaid at their local department of social services.

B. Nonfinancial Eligibility

An individual who is receiving an SSI payment is eligible for Medicaid if he meets the following nonfinancial requirements:

1. Citizenship or Alien Status
   The SSI recipient is a citizen of the United States or full benefit alien (see M0220).

2. Virginia Residency
   The SSI recipient is a resident of Virginia (see M0230).

3. Assignment Of Rights
   The SSI recipient meets the assignment of rights to medical support and third party payments requirements (see M0250).

4. Institutional Status
   The SSI recipient meets the institutional status requirements in M0280.

5. Not Conditionally Or Presumptively Eligible
   The SSI recipient is NOT conditionally or presumptively eligible for SSI, or is not presumptively disabled or blind. Conditionally eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made.

6. SSI Entitlement
   SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. When the SSA record indicates a payment code of “C01” but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient.

   Eligibility for months prior to SSI entitlement must be evaluated in other covered groups.
C. Financial Eligibility

1. Resources

a. Asset Transfer

The SSI recipient must meet the asset transfer policy in subchapter M1450. See subchapter M1450 to determine if the asset transfer precludes Medicaid eligibility for the Medicaid payment of long-term services.

b. Resource Eligibility

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to his home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

2) an interest in undivided heir property and the equity value of his share when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;

3) ownership (equity value) of his former residence and the SSI recipient is in an institution for longer than 6 months. Determine if the former home is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly with another person, to whom the SSI recipient is not married, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements.

Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible as medically indigent (which has more liberal resource methods and standards).
of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the recipient’s full coverage effective the last day of the month, using cancel reason “007.” Reinstall the recipient’s coverage with the begin date as the first day of the month following the cancellation effective date. The aid category (AC) is “053.”

3. **SLMB’s AC Changes To Full Coverage AC**

   When an enrolled SLMB becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB’s resources change to below the MN limits:

   - cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason “024”;
   - reinstate the recipient’s coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. **Spenddown Status**

   At application and redetermination, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

   SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

6. **SLMB Meets Spenddown**

   When an SLMB meets a spenddown, cancel his AC “053” coverage effective the date before the spenddown was met, using cancel reason “024”. Reinstall the recipient’s coverage with the begin date as the first date the spenddown was met, and enter the end date of the spenddown period. The AC is medically needy NOT dual-eligible:

   - 018 for an aged MN individual NOT eligible as QMB;
   - 038 for a blind MN individual NOT eligible as QMB;
   - 058 for a disabled MN individual NOT eligible as QMB.
6. Spenddown Period Ends

After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.

The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

7. SLMB Enters Long-term Care

The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason “024”. Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.208 QUALIFIED INDIVIDUALS-(QI)

A. Policy

P.L. 105-33 (Balanced Budget Act of 1997) mandated Medicaid coverage of Qualified Individuals who would be Qualified Medicare Beneficiaries (QMBs) except that their income exceeds the QMB income limit. When implemented on January 1, 1998, the QI covered group consisted of two components, Group 1 and Group 2. Group 1 individuals receive Medicaid coverage for the payment of their Medicare Part B premium. Group 2 individuals receive Medicaid coverage for the portion of the Medicare Part B premium that is attributable to the cost of transferring coverage of home health services to Medicare Part B from Part A. The federal authority for Group 2 expired and Medicaid coverage for this component ended December 31, 2002. Effective January 1, 2003, the QI covered group consists only of the component formerly referred to as “Group 1.”

QI funds are maintained in the MMIS for the current and previous year only.

Like QMBs and SLMBs, eligible QIs are also placed on a medically needy spenddown if resources are within the medically needy limit.

1. Not An Entitlement

Medicaid coverage for this covered group is not an individual entitlement, which means that when the Department of Medical Assistance Services (DMAS) runs out of money for this covered group, no additional eligible individuals in this covered group will receive Medicaid benefits. DMAS will notify the DSS Central Office when the money for this covered group will run out.

Local departments of social services must continue to take and process applications for this covered group even after the funds run out. The MMIS will generate and send a notice to the recipient if the recipient will not receive the benefit because the funds have run out.

Applications for QI coverage for an upcoming year may not be taken until January 1 of that year.
D. QI Coverage Period

If all eligibility factors are met in the application month, eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. Applications for QI coverage for an upcoming year may not be taken until January 1 of that year, and coverage under this group cannot begin earlier than January 1 of the calendar year. The Notice of Action on Medicaid must state the recipient’s begin and end dates of Medicaid coverage.

QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year.

E. Covered Service

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

F. Enrollment

1. Aid Category

QI = 056

2. Begin and End Dates

The begin date of coverage cannot be any earlier than January 1 of the calendar year. An edit is in place in the MMIS to prevent enrollment prior to January 1 of the current year.

Do not enter an end date of coverage. The MMIS will automatically cancel the recipient’s coverage on December cut-off, effective December 31 of the calendar year.

3. Recipient’s Covered Group Changes To QI

a. Before November Cut-off

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

Cancel the recipient’s full coverage effective the last day of the month, using cancel reason “007”. Reinstall the recipient’s coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate AC.
b. After November Cut-off

If, after **November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient to cancel the recipient’s Medicaid coverage effective December 31. The notice must specify that he must reapply for Medicaid if he/she wants Medicaid to pay his/her Medicare Part B premium. Cancel the recipient’s full coverage effective December 31, using cancel reason “07”.

G. MMIS Procedures For QI Recipients

The MMIS computer will

- automatically cancel the QI recipient’s coverage effective December 31 of each calendar year, and
- send a notice to the recipient to reapply for Medicaid coverage for the next calendar year.
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 ≤ 80% of the FPL and are in section M0810.002.
   The income requirements in chapter S08 must be met.

5. Income Exceeds 80% FPL
   **Spenddown does not apply** to this covered group. If the individual’s income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual’s eligibility in all other Medicaid covered groups.

D. Entitlement

1. Begin Date
   If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

2. Retroactive Entitlement
   ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment
   The ABD 80% group AC is:
   - 029 for an aged enrollee;
   - 039 for a blind enrollee; or
   - 049 for a disabled enrollee.

M0320.211 MEDICAID WORKS

A. Policy
   The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals who are:
   - at least age 16 and are under age 65, and
• who have countable income less than or equal to 80% of the FPL, and

• who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; and

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

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

B. Nonfinancial Eligibility

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

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

The individual must also meet the following additional nonfinancial criteria:

• The individual must not be receiving Medicaid covered long-term care services.

• The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is not considered competitive employment in an integrated setting.

• The individual must receive pay at the minimum wage or at the prevailing wage or “going rate” in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
• The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings accounts. The individual must provide documentation for the case record designating the account(s) as a WIN Account.

• All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on the LDSS Intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi. The agreement outlines the individual’s responsibilities as an enrollee in the program.

• The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. The monthly premium will be waived for the first six months of the program (January 1, 2007 through June 30, 2007).

C. Financial Eligibility

1. Assistance Unit
   a. Initial eligibility determination

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

   b. Ongoing eligibility

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

2. Resources
   a. Initial eligibility determination

   For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual’s countable, nonexempt resources must be verified. All countable resources must be added together to determine if the individual’s countable resources are within the limit.
b. **Ongoing eligibility**

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

i. **For earnings accumulated after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2006 is $26,356.

ii. Resources held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. IRS-approved accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

iii. **For all other resources,** the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in i or ii above is $2,000 for an individual.

3. **Income**

   a. **Initial eligibility determination**

   For the initial eligibility determination, the income limit is \( \leq 80\% \) of the FPL (see M0810.002). The income requirements in chapter S08 must be met.

   b. **Ongoing eligibility**

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

   i. **The income limit for earned income is 200% of the FPL for one person** (see M0810.002) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.
If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual’s signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

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

4. Income Exceeds 80% FPL at Eligibility Determination

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

D. Cost Sharing and Premium Payment

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

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

Note: premiums will be waived for the first six months of the MEDICAID WORKS Program (January 1, 2007 through June 30, 2007).

E. Good Cause

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

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months as long as any required premium payments continue to be made (premiums will be waived from January 1, 2007 through June 30, 2007). The six-month period begins the first day of the month following the month in which the job loss occurred. The individual must provide documentation that he is unable to work from a medical or mental health practitioner or employer.

- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to illness or unavoidable job loss must be submitted to DMAS on the enrollee’s behalf by the local department of social services.
F. Safety Net

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

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

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

Resources retained in an IRS-approved account described in M0320.211 C.2.b.ii are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

G. Benefit Package

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

H. Entitlement and Enrollment

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

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

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The individual’s continuing eligibility must be determined at least every 12 months.
If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. The policy in M0320.211 F. above must be reviewed to determine whether the safety net rules apply. If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

The AC for MEDICAID WORKS is 059.

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 ≤ 300% SSI;
- M0320.310 F&C Receiving Waiver Services (CBC);
- M0320.311 F&C Hospice;
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 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 newborn child born to an alien eligible for Medicaid payment of emergency services only does NOT meet the MI Newborn Children covered group.
pregnancy and the 60-day period following the end of her pregnancy. Medicaid coverage ends the last day of the month in which the 60th day occurs.

E. Enrollment

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

The PD for newborns is “93.”

M0320.302 FAMILY PLANNING SERVICES (FPS)

A. Policy

Chapter 899 of the 2002 Acts of Assembly, Item 325 M, directs DMAS to provide payment for Family Planning Services (FPS). Effective October 1, 2002, women who receive a pregnancy-related service paid for by Medicaid may receive up to 24 months of family planning services following the end of their pregnancy. Since women enrolled in the MI Pregnant Woman covered group receive 60 days of postpartum coverage with full Medicaid benefits, they are eligible to receive 22 months of family planning services following the end of their pregnancy and the 60-day postpartum period. *FPS is limited to women who have not had a sterilization procedure.*

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

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

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

Retroactive coverage is available for FPS.

B. Nonfinancial Requirements

Women in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02:
- citizenship/alien status (emergency services aliens described in M0220.700 are not eligible); Virginia residency;
- Social Security number;
- assignment of rights to medical benefits;
- application for other benefits; and
- institutional status.

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

C. Financial Eligibility

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

2. Asset Transfer
   The asset transfer rules do not apply to the FPS covered group.

3. Resources
   There is no resource limit.

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

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

   An income eligibility determination is required for:

   - women enrolled in the MI Pregnant Women covered group who received a Medicaid covered pregnancy-related service whose pregnancy ended on or after October 1, 2002, but prior to October 1, 2003; and

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

5. Spenddown
   Spenddown does not apply to this covered group.
D. Entitlement and Enrollment

1. Entitlement

Eligibility in the FPS covered group cannot extend beyond the 24th month following the end of a woman’s pregnancy. The woman is entitled to coverage in the FPS covered group for 12 months (including the 60-day post-partum period) from the date the pregnancy ends. Changes in income during the first 12 months of FPS coverage do not affect the woman’s eligibility for FPS.

Women who were not enrolled in the MI Pregnant Women covered group who had a Medicaid covered pregnancy-related service must have an eligibility determination. If the woman does not meet a covered group entitled to full Medicaid benefits, but meets the requirements of the FPS covered group, she is to be enrolled in FPS.

Written notice must be sent to inform the recipient of her eligibility in the FPS covered group and of the reduction in coverage. She must also be advised of the opportunity to receive a redetermination of eligibility for full coverage.

2. Enrollment

The eligibility worker must cancel the MI Pregnant Women enrollment effective the last day of the month of the 60-day postpartum period and reinstate the woman’s coverage in FPS the first day of the following month.

The AC for FPS is “080.”

The eligibility worker must enter the actual date of the child’s birth, or the actual date the pregnancy terminated, in the Expected Delivery Date field on the recipient’s demographics screen in MMIS. MMIS will automatically send the advance notice and cancel FPS coverage 24 months after the pregnancy ends, unless the woman becomes ineligible for FPS services after the 12th month from the end of pregnancy and her coverage is canceled by the worker. The MMIS will cancel this coverage using reason code “036.” MMIS will also cancel FPS coverage if a sterilization procedure is billed to Medicaid.

The eligibility of a woman enrolled in FPS must be evaluated 12 months following the end of the pregnancy. If the woman continues to be eligible for FPS, her coverage may continue for an additional 12 months. Changes in income after the first 12 months of FPS coverage must be evaluated. See section M1520.200 C for the FPS renewal requirements.

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

A. Policy

Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable
income is less than or equal to
100% of the FPL and allows states to cover children at higher income limits. Virginia has elected to cover children from age 6 to age 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families’ resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

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

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

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

C. Financial Eligibility

1. Assistance Unit

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

2. Asset Transfer

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

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

5. Income Changes

Any changes in an MI child’s income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

6. Income Exceeds MI Limit

A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia’s Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child’s income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.
and parents or caretaker-relatives of dependent children who participate in
the Virginia Initiative for Employment not Welfare (VIEW) component of
the Virginia Independence Program (VIP) and meet the requirements of the
1115 waiver. This covered group is called “Low Income Families With
Children” (LIFC).

B. Nonfinancial Eligibility

The individual must meet all the nonfinancial eligibility requirements in
chapter M02.

The child(ren) must meet the definition of a dependent child in
M0310.111. The adult with whom the child lives must be the child’s
parent or must meet the definition of a caretaker-relative of a dependent
child in M0310.107. A child or adult who lives in the household but who
is not the dependent child’s parent or caretaker-relative may be eligible as
LIFC if he/she meets the definition of an EWB in M0310.113.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in subchapter M0520 applies to the LIFC
covered group. The assistance unit’s financial eligibility is determined
first. If the family unit has resources or income that cannot be verified
or that exceeds
the amount for the individual’s covered group, the family unit is
divided
into budget units, if appropriate.

If the LIFC individual is living with his/her spouse or child who is
aged,
blind, or disabled, two different financial calculations must be
completed
for the unit if the family unit does not meet the LIFC resource and
income limits, because of the different resource and income rules and
the different resource and income limits used in the F&C and ABD
determinations.

2. Asset Transfer

The asset transfer rules in subchapter M1450 must be met by an LIFC
individual.

3. Resources

*There is no resource test for the LIFC covered group.*
4. Income

a. Non-View Participants

The income requirements in chapter M07 must be met by the LIFC group. The income limits are in M0710.002.

b. View Participants

The income requirements in chapter M07 must be met by VIEW participants. The method for determining income eligibility is different for VIEW participants and is found in M0710.730 D. The income limits are in M0710.002.

5. Income Exceeds CNNMP Limit

Spenddown does not apply to the CNNMP income limits. If the family/budget unit’s (FU/BU’s) income exceeds the F&C CNNMP income limit, the unit is not eligible as CNNMP LIFC and cannot spenddown to the CNNMP limit. If resources are within the medically needy limit, the unit may be placed on spenddown if at least one member meets an MN covered group, such as MN children under age 18.

D. Entitlement

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

E. Enrollment

The ACs for individuals in the LIFC covered group are:

- 081 for an LIFC individual in a family with one or no parent in the home;
- 083 for LIFC individuals in a two-parent household.

M0320.307 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 - The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the resource and income requirements of the state’s July 16, 1996 AFDC State Plan. These reasonable classifications of individuals under age 21 are:

- individuals in foster homes, private institutions or independent living arrangements for whom a public agency is assuming full or partial financial responsibility;

  NOTE: A foster care child in a non-custodial agreement who is in an independent living situation meets this requirement and is eligible in this covered group;

- individuals placed in foster homes or private institutions by private nonprofit child placing agencies;
M0520.000 FAMILIES & CHILDREN (F&C) FAMILY/BUDGET UNIT

M0520.001 OVERVIEW

A. Introduction

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

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

B. Policy

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

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

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

1. Member In One Unit

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

2. May Exclude A Child

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

3. Living Away From Home

A parent, or a child under age 21 who has not been emancipated, is considered living in the household for family unit composition purposes if the absence is temporary and the parent or child intends to return to the home when the purpose of the absence (such as employment, military service, education, rehabilitation, medical care, vacation, visit) is completed.
Children living in foster homes institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

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

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

C. Procedure

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

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

M0520.010 DEFINITIONS

A. Introduction

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

B. Acknowledged Father

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

- the man has been found by a court to be the child’s father;
- the man has admitted paternity either before a court, or voluntarily in writing, under oath;
- the man has been found by a blood test to be the child’s father;
- the man’s name appears on the child’s official birth certificate;
C. Household
For this subchapter’s purposes, the “household” is everyone living in the residence and who is listed on the Application for Benefits as living in the residence.

D. Legal Emancipation
"Legal emancipation" from parents means that the parents and child have gone through court and a judge has declared that the parents have surrendered the right to the care, custody and earnings of the child and have renounced parental duties.

A married Medicaid minor is NOT emancipated unless a court has declared the married minor emancipated from his or her parent(s).

E. Legally Responsible Relative
A legally responsible relative is a person who is related to the individual applicant or recipient and who has a legal obligation under federal and state law to support the individual applicant(recipient).

Under federal Medicaid law and regulations, the only relatives who are legally responsible relatives are the following relative(s) with whom the individual applicant or recipient lives:

- the individual’s spouse, and
- the individual’s parent if the individual is a child under age 21 years.

F. Medicaid Minor
A child under age 21 years is a Medicaid minor.

M0520.100 FAMILY UNIT RULES

A. Introduction
This section contains the rules that apply to the family unit within a household applying for Medicaid. The family unit consists of the individuals in the household among whom legal responsibility for support exists. A parent or non-parent caretaker can choose to exclude any child from the family unit by excluding the child from the Medicaid application (see M0520.001 B).

B. Family Unit Composition
When determining composition of the F&C family unit, start with the individual who applies for Medicaid and who meets an F&C covered group’s requirements. These covered groups are:

- Pregnant women (MI and MN);
- Low income families with children (LIFC) (CNNMP);
- Newborn children (MI and MN);
- Children under age 19 (MI);
• Children under age 18 (MN);
• Individuals < 21 in foster care, adoption assistance, and ICF or an ICF-MR (CNNMP and MN).

Begin forming the family unit(s) by identifying a pregnant woman in the household, if any. If the household does not contain a pregnant woman, begin forming the family unit(s) by identifying the child(ren) who meets an F&C covered group.

1. **Member In One Unit At A Time**

   An applicant/recipient's Medicaid eligibility can only be determined in one F&C family unit at a time.

2. **Include Responsible Relative(s)**

   The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse), EXCEPT when:

   - the child is in foster care and is placed in his/her home for a trial visit; or
   - the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Do not include SSI and IV-E Foster Care/Adoption Assistance recipients in the unit.

Include a TANF recipient who is a responsible relative in the unit but do **not count the TANF grant as income**. Non-TANF income is counted as income to the unit.

The unit must also include all individuals in the household for whom each individual in the unit is legally responsible except

- excluded individuals;
- SSI recipients, and
- IV-E recipients.

For example, a child age 10 lives with his mother and his 5 year-old sister who receives SSI; all are included on the application. The family unit consists of the 10 year old child and his mother who is legally responsible for him, but not his SSI recipient sister even though the mother is also legally responsible for her.

3. **Child Under 21 Living Away From Home**

   A child under age 21 who is living away from home is considered living with his/her parent(s) in the household for family unit composition purposes if:

   - the child is not emancipated, and
   - the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.
Deeming Allocations

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

### NBD (Non-blind/disabled) Child Allocation

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

\[
\text{SSI payment for couple} - \text{SSI payment for one person} = \text{NBD child allocation}
\]

- **2007:** $934 - $623 = $311
- **2006:** $904 - $603 = $301

### Parental Living Allowance

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

\[
\text{SSI payment for one person} = \text{SS}I \text{ payment for one person}
\]

- **2007:** $623
- **2006:** $603

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

\[
\text{SSI payment for both parents} = \text{SS}I \text{ payment for both parents}
\]

- **2007:** $934
- **2006:** $904

### Deeming Standard

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

\[
\text{SSI payment for couple} - \text{SSI payment for one person} = \text{deeming standard}
\]

- **2007:** $934 - $623 = $311
- **2006:** $904 - $603 = $301
## TABLE OF CONTENTS

### M07 FAMILIES AND CHILDREN INCOME

#### M0720.000 F & C EARNED INCOME

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td>Wages</td>
<td>1</td>
</tr>
<tr>
<td>Income From a Corporation</td>
<td>2</td>
</tr>
<tr>
<td>How to Count Income In The Retroactive Period</td>
<td>2</td>
</tr>
<tr>
<td>How To Estimate Earned Income</td>
<td>2</td>
</tr>
<tr>
<td>Income From Self-Employment</td>
<td>5</td>
</tr>
<tr>
<td>Income From Real Property</td>
<td>6</td>
</tr>
<tr>
<td>Income From Room and Board</td>
<td>6</td>
</tr>
<tr>
<td>Income From Day Care</td>
<td>7</td>
</tr>
<tr>
<td>Income From Small Businesses/Cash Crops</td>
<td>8</td>
</tr>
<tr>
<td>Income From Uniformed Services (Military)</td>
<td>8a</td>
</tr>
<tr>
<td>Contract Income</td>
<td>9</td>
</tr>
<tr>
<td>Earned Income Exclusions</td>
<td>10</td>
</tr>
<tr>
<td>Workforce Investment Act Exclusion</td>
<td>12</td>
</tr>
<tr>
<td>Student Child Earned Income Exclusion</td>
<td>12</td>
</tr>
<tr>
<td>Standard Work Exclusion</td>
<td>13</td>
</tr>
<tr>
<td>$30 Plus 1/3 Earned Income Exclusion</td>
<td>13</td>
</tr>
<tr>
<td>$30 Earned Income Exclusion</td>
<td>16</td>
</tr>
<tr>
<td>Child Care/Incapacitated Adult Care Exclusion</td>
<td>17</td>
</tr>
</tbody>
</table>

### APPENDIX

Families & Children Earned Income Exclusions .................................................. Appendix 1 .......... 1
available continues until the 8 consecutive months has ended. If the individual is not enrolled in Medicaid in the LIFC covered group in any of the following 8 consecutive months, the individual will not receive the $30 earned income exclusion.

**EXAMPLE #5:** A LIFC recipient becomes employed in January and receives the $30 plus 1/3 earned income exclusion for February, March, April and May. She is entitled to a $30 earned income exclusion for the 8-month period of June through January. She requests her case be closed in June. The 8-month time period for the $30 earned income exclusion continues to run. In February she reapplies and is employed. She is not eligible to receive the $30 earned income exclusion.

c. **Reapplies in 8-Month Period**

If an individual becomes ineligible for Medicaid for any reason and reapplies during the 8-month $30 earned income exclusion period, the individual will be eligible for the exclusion for the remaining months of the 8-month period.

**EXAMPLE #6:** A LIFC recipient becomes employed in January and receives the $30 plus 1/3 exclusion on earned income received in February, March, April and May. She is entitled to a $30 earned income exclusion on income received in June through January. The recipient requests her case be closed in July. The 8-month period continues to run. She re applies in September and is found eligible. The $30 earned income exclusion applies to her earnings in the months of September through January.

d. **Received $30 Earned Income Exclusion For Less than Eight Months Due to Loss of Earnings**

If an individual receives the $30 earned income exclusion for less than 8 months because of a loss of earnings, the individual will again be eligible for the remaining months of the 8-month period if the individual receives earned income.

**EXAMPLE #7:** Mrs. Tan, a Medicaid recipient, received the $30 plus 1/3 earned income exclusion in January, February, March, and April (first 4 consecutive months). She received the $30 earned income exclusion in May and June. She loses her job in June. In August, she becomes employed. She is eligible for the $30 earned income exclusion for the months of September through December.

**M0720.540 CHILD CARE/INCAPACITATED ADULT CARE EXCLUSION**

**A. Policy**

Anticipated child or incapacitated adult care expenses paid or anticipated to be paid by the family/budget unit for children or incapacitated adults in the family unit, up to the appropriate maximums, must be excluded from earned income in determining Medicaid eligibility when the expenses are
necessary because of employment or seeking employment. When both parents are in the household, both parents must be employed or seeking employment to allow the child care/incapacitated adult care exclusion. The child care/incapacitated adult care exclusion is based on an individual’s employment status.

For LIFC, the child or incapacitated adult care exclusion is not allowed in the 185% screening.

B. Definitions

1. Full-time Employment

   Full-time employment means employed to work 30 hours or more per week on an on-going basis; or working, or expected to work 120 hours or more per month (for an individual working on a fluctuating basis).

2. Part-time Employment

   Part-time employment means employed to work less than 30 hours per week on an on-going basis; or working or expected to work less than 120 hours per month (for an individual working on a fluctuating basis).

3. Not Employed Throughout a Month

   Not employed throughout a month means an individual began or terminated employment within the month.

C. Operating Principle

1. Verification

   a. Incapacity

   Incapacity of the adult who requires care must be supported by a professional determination. The medical examination for Medicaid and GR is used for this purpose, unless incapacity is established by receipt of Social Security Disability benefits.

   b. Employment Status

   An individual’s employment status is verified by either an employer's statement of the number of hours employed to work, or actually worked or by pay stubs. For self-employed individuals, the agency is required to accept the client's statement concerning the number of hours worked, unless the agency has reason to question the validity of the statement.

   c. Expenses

   Verification of child/incapacitated adult care expenses is not required. Accept the parent/caretaker's declaration of the amount of the child/incapacitated adult care expense.

2. Amount of Exclusion

   a. Full-time Employment

   For full-time employment, deduct an amount equal to the anticipated cost, not to exceed $175 per month, for care of each child, age 2 and older and/or incapacitated adult in the family unit. In the case of child care for a child under 2 years old, deduct the anticipated cost not to exceed $200 per month.
b. Part-time Employment

For part-time employment, deduct an amount equal to the anticipated cost, not to exceed $120 per month, for care of each child and/or incapacitated adult in the family unit.

c. Not Employed Throughout a Month

1) If an individual has worked, or is expected to work, 120 hours or more in that month, deduct an amount not to exceed the full-time exclusion.

2) If an individual has worked, or is expected to work, less than 120 hours in that month, deduct an amount not to exceed the part-time exclusion.

3. Conversion to Monthly Amount

If child care/incapacitated adult care is payable on a weekly or bi-weekly basis, the amount of the monthly expense may be calculated using the 4.3 (weekly), or 2.15 (bi-weekly), or 2 (semi-monthly) conversion factors.
### FAMILIES & CHILDREN EARNED INCOME EXCLUSIONS

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

M0810.001 INCOME AND ELIGIBILITY

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

B. Policy Principles

1. Who is Eligible
An individual is eligible for Medicaid if the person:

- meets a covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group's income limits.

2. General Income Rules
- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

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

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

2. Categorically Needy Non-Money Payment-Protected Covered Groups Which Use SSI Income Limits

<table>
<thead>
<tr>
<th>Family Unit Size</th>
<th>2007 Monthly Amount</th>
<th>2006 Monthly Amount</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$623</td>
<td>$603</td>
</tr>
<tr>
<td>2</td>
<td>934</td>
<td>904</td>
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</table>

Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them

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<thead>
<tr>
<th>Family Unit Size</th>
<th>2007 Monthly Amount</th>
<th>2006 Monthly Amount</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$415.33</td>
<td>$402</td>
</tr>
<tr>
<td>2</td>
<td>622.67</td>
<td>602.67</td>
</tr>
</tbody>
</table>
3. **Categorically Needy-Non Money Payment (CNNMP) – 300% of SSI**

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

<table>
<thead>
<tr>
<th>Family Size Unit</th>
<th>2007 Monthly Amount</th>
<th>2006 Monthly Amount</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,869</td>
<td>$1,809</td>
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</tbody>
</table>

4. **Medically Needy**

<table>
<thead>
<tr>
<th>Family Unit Size</th>
<th>Semi-annual</th>
<th>Monthly</th>
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<tr>
<td>1</td>
<td>$1,506.87</td>
<td>$251.14</td>
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<td>2</td>
<td>$1,918.80</td>
<td>$319.80</td>
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</table>

<table>
<thead>
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<tr>
<td>1</td>
<td>$1,738.70</td>
<td>$289.78</td>
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<td>2</td>
<td>$2,141.31</td>
<td>$356.88</td>
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</table>

<table>
<thead>
<tr>
<th>Family Unit Size</th>
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<th>Monthly</th>
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<tr>
<td>1</td>
<td>$2,260.30</td>
<td>$376.71</td>
</tr>
<tr>
<td>2</td>
<td>$2,725.36</td>
<td>$454.22</td>
</tr>
</tbody>
</table>

5. **ABD Medically Indigent**

For:
- ABD 80% FPL, QMB, SLMB, & QI without Social Security (SS) and QDWI, effective 1/24/06;
- ABD 80% FPL, QMB, SLMB, & QI with SS, effective 3/01/06; and MEDICAID WORKS, effective 1/1/07

<table>
<thead>
<tr>
<th>ABD 80% FPL</th>
<th>Annual</th>
<th>Monthly</th>
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<tr>
<td>1</td>
<td>$7,840</td>
<td>$654</td>
</tr>
<tr>
<td>2</td>
<td>$10,560</td>
<td>880</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>QMB 100% FPL</th>
<th>Annual</th>
<th>Monthly</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>$9,800</td>
<td>$817</td>
</tr>
<tr>
<td>2</td>
<td>$13,200</td>
<td>1,100</td>
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</table>

<table>
<thead>
<tr>
<th>SLMB 120% of FPL</th>
<th>Annual</th>
<th>Monthly</th>
</tr>
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<tr>
<td>1</td>
<td>$11,760</td>
<td>$980</td>
</tr>
<tr>
<td>2</td>
<td>$15,840</td>
<td>1,320</td>
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</table>

<table>
<thead>
<tr>
<th>QI 135% FPL</th>
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<th>Monthly</th>
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<tr>
<td>1</td>
<td>$13,230</td>
<td>$1,103</td>
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<td>2</td>
<td>$17,820</td>
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<table>
<thead>
<tr>
<th>QDWI and MEDICAID WORKS 200% of FPL</th>
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<th>Monthly</th>
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<tbody>
<tr>
<td>1</td>
<td>$19,600</td>
<td>$1,634</td>
</tr>
<tr>
<td>2</td>
<td>$26,400</td>
<td>2,200</td>
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</table>
C. Procedure

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

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

3. Expenses of Obtaining Income
   DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)

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

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

EARNED INCOME EXCLUSIONS

S0820.500 GENERAL

A. Policy

1. General
   The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.

2. Other Federal Laws
   First, income is excluded as authorized by other Federal laws.
3. Other Earned Income

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

a. Federal earned income tax credit payments

b. Up to $10 of earned income in a month if it is infrequent or irregular

c. For 2006, up to $1,460 per month, but not more than $5,910 in a calendar year, of the earned income of a blind or disabled student child.

For 2007, up to $1,510 per month, but not more than $6,100 in a calendar year, of the earned income of a blind or disabled student child.

d. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month

e. $65 of earned income in a month

f. Earned income of disabled individuals used to pay impairment-related work expenses

g. One-half of remaining earned income in a month

h. Earned income of blind individuals used to meet work expenses

i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

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

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

5. Couples

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

B. References

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

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

For exclusions applicable only to earned income, see S0820.510 - S0820.570.
S0820.510   STUDENT CHILD EARNED INCOME EXCLUSION

A.  Policy

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

<table>
<thead>
<tr>
<th>For Months</th>
<th>Up to per month</th>
<th>But not more than in a calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>In calendar year 2006</td>
<td>$1,460</td>
<td>$5,910</td>
</tr>
<tr>
<td>In calendar year 2007</td>
<td>$1,510</td>
<td>$6,100</td>
</tr>
</tbody>
</table>

2.  Qualifying for the Exclusion
   The individual must be:
   - a child under age 22; and
   - a student regularly attending school.

3.  Earnings Received Prior to Month of Eligibility
   Earnings received prior to the month of eligibility do not count toward the yearly limit.

4.  Future Increases
   The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year’s amounts. However, there may be years when no increases result from the calculation.

B.  Procedure

1.  Application of the Exclusion
   Apply the exclusion:
   - consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
   - only to a student child’s own income.

2.  School Attendance and Earnings
   Develop the following factors and record them:
   - whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
   - the amount of the child’s earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

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

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

D. Example

(Using April 2002 Figures)

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

June, July and August
$1600.00 gross earnings
- $1320.00 student child exclusion
  $ 280.00
- $ 20.00 general income exclusion
  $ 260.00
- $ 65.00 earned income exclusion
  $ 195.00
- $ 97.50 one-half remainder
  $ 97.50 countable income

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

September
$800.00 gross earnings
- $800.00 student child exclusion
  0 countable income

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

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

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

## S1130.000 ABD RESOURCES EXCLUSIONS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REAL PROPERTY</strong></td>
<td></td>
</tr>
<tr>
<td>The Home</td>
<td>M1130.100</td>
</tr>
<tr>
<td>Home Replacement Funds</td>
<td>S1130.110</td>
</tr>
<tr>
<td>Real Property Whose Sale Would Cause Undue Hardship, Due to Loss of Housing, To a Co-Owner - For QMB, SLMB, QI and ABD 80% FPL Only</td>
<td>S1130.130</td>
</tr>
<tr>
<td>Real Property Following Reasonable but Unsuccessful Efforts to Sell</td>
<td>M1130.140</td>
</tr>
<tr>
<td>Interests of Individual Indians in Trust or Restricted Lands</td>
<td>S1130.150</td>
</tr>
<tr>
<td>Other Real Property</td>
<td>M1130.160</td>
</tr>
<tr>
<td><strong>PERSONAL PROPERTY</strong></td>
<td></td>
</tr>
<tr>
<td>Automobile</td>
<td>M1130.200</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>M1130.300</td>
</tr>
<tr>
<td>Burial Spaces</td>
<td>M1130.400</td>
</tr>
<tr>
<td>Burial Funds Exclusion -- August 1, 1994 and Continuing</td>
<td>M1130.410</td>
</tr>
<tr>
<td>Burial Funds Exclusion -- July 1, 1988 Through July 31, 1994</td>
<td>M1130.411</td>
</tr>
<tr>
<td>Prepaid Burial Contracts</td>
<td>M1130.420</td>
</tr>
<tr>
<td>Life Insurance Funded Burial Contracts and the Burial Space/Funds Exclusion</td>
<td>M1130.425</td>
</tr>
<tr>
<td>Household Goods and Personal Effects</td>
<td>M1130.430</td>
</tr>
<tr>
<td><strong>REAL OR PERSONAL PROPERTY</strong></td>
<td></td>
</tr>
<tr>
<td>Property Essential to Self-Support - Overview</td>
<td>S1130.500</td>
</tr>
<tr>
<td>Essential Property Excluded Regardless of Value or Rate of Return</td>
<td>S1130.501</td>
</tr>
<tr>
<td>Essential Property Excluded up to $6,000 Equity Regardless of Rate of Return</td>
<td>S1130.502</td>
</tr>
<tr>
<td>Essential Property Excluded up to $6,000 Equity if It Produces a 6 Percent Rate of Return</td>
<td>S1130.503</td>
</tr>
<tr>
<td>Essential Property - Current Use Criterion</td>
<td>S1130.504</td>
</tr>
<tr>
<td>Resources Set Aside as Part of a Plan for Achieving Self-Support</td>
<td>S1130.510</td>
</tr>
<tr>
<td>Trusts Established Between July 1, 1993 and August 11, 1993</td>
<td>M1130.520</td>
</tr>
</tbody>
</table>
S1130.000 ABM RESOURCES EXCLUSIONS

Section Page

RETAINED CASH AND IN-KIND PAYMENTS

Retroactive SSI and RSDI Payments ..................................................... S1130.600 ......................... 62
Netherlands WUV Payments to Victims of Persecution .................. S1130.605 ......................... 63
German Reparations Payments ......................................................... S1130.610 ......................... 64
Austrian Social Insurance Payments .................................................. S1130.615 ......................... 65
Disaster Assistance ........................................................................... S1130.620 ......................... 66
Cash and In-Kind Items Received for the Repair or Replacement of Lost, Damaged, or Stolen Excluded Resources ......................................................... S1130.630 ......................... 67
Benefits Excluded from Both Income and Resources by a Federal Statute Other Than Title XVI .................. S1130.640 ......................... 70
Agent Orange Settlement Payments .................................................. S1130.660 ......................... 70
Victim’s Compensation Payments ..................................................... S1130.665 ......................... 71
State or Local Relocation Assistance Payments .............................. S1130.670 ......................... 72
Tax Advances and Refunds Related to Earned Income Tax Credits ......................................................... S1130.675 ......................... 73
Radiation Exposure Compensation Trust Fund Payments .............. S1130.680 ......................... 74
Walker v. Bayer Settlement Payments .............................................. M1130.685 ......................... 75

COMMINGLED FUNDS

Identifying Excluded Funds That Have Been Commingled With Nonexcluded Funds ......................................................... S1130.700 ......................... 76

Appendix

Determining the Countable Value of Real Property ....................... Appendix 1 ......................... 1
ABD Home Property Evaluation Worksheet .................................. Appendix 2 ......................... 1
PERSONAL PROPERTY

M1130.200 AUTOMOBILES

A. Policy Principles

1. Automobile Defined
   For ABD Medicaid purposes, "automobile" means any vehicle used for transportation. It thus can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and animals that are used for transportation. Animals that are kept primarily for recreational purposes, such as horses, are not considered vehicles if they are not used primarily for transportation.

2. Current Market Value Defined
   The CMV of an automobile is the average trade-in value listed in the NADA Guide.

3. Exclusion Regardless of Value
   Ownership of one motor vehicle does not affect eligibility. One automobile, regardless of value, is excluded for the individual or a member of the individual's household.

4. Other Automobiles
   Any automobile an individual owns in addition to the one excluded will be evaluated as a countable resource.

5. Rebuttal of NADA Value
   If the individual disagrees with the NADA value, he must be given the opportunity to rebut it. Rebuttal evidence consists of one written appraisal for the automobile's value from a knowledgeable source, such as a used vehicle dealer or an automobile insurance company.

6. Rebuttal of Ownership
   Assume that the individual owns the automobile if his name appears on the title or note or if he is listed as the owner in Division of Motor Vehicles’ records. The principle of “equitable ownership,” however, applies to situations in which one individual’s name appears on the records of ownership but another person actually paid for and uses the automobile. If the applicant or enrollee wishes to rebut ownership of a vehicle, he must be given the opportunity to provide evidence that he does not have equitable ownership in the vehicle. Rebuttal evidence consists of:

   - a statement from the applicant/enrollee and the other individual indicating why the automobile is listed in the applicant’s/enrollee’s name, including the person who actually uses the automobile and in whose possession it is kept, and

   - cancelled checks or records from the lender indicating that the other individual has made all payments on the automobile.

   If the applicant/enrollee does not use the automobile and can provide documentation that another person has made all the payments on the automobile, it is not a resource to the applicant/enrollee.
B. Operating Policy--More than One Automobile Owned

1. General Rule
   If more than one automobile is owned, one automobile will be excluded and the other will be a countable resource. The exclusion will apply to the automobile with the highest equity value.

2. Determining Equity Value
   Use the following method to determine equity value:
   - Determine the average trade-in value for each automobile from the NADA Guide. In the event the automobile is not listed, the value assessed by the locality for tax purposes may be used.
   - Determine the equity value in each automobile by subtracting the debt from NADA value.
   - Exempt the automobile with the highest equity value.

3. References
   See M1110.400 for what values apply to resources.
   See Appendix 1 for QDWI development.

M1130.300 LIFE INSURANCE

A. Definitions

1. Life Insurance Policy
   A life insurance policy is a contract. Its purchaser (the owner) pays premiums to the company that provides the insurance (the insurer). In return, the insurer agrees to pay a specified sum to a designated beneficiary upon the death of the insured (the person on whom, or on whose life, the policy exists).

2. Face Value
   Face value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such, or as the "amount of insurance," the amount of the policy," the sum insured," etc. A policy's FV does not include:
   - the FV of any dividend addition, which is added after the policy is issued (see 5. below);
   - additional sums payable in the event of accidental death or because of other special provisions; or
   - the amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other(s).

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

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

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

5. **Dividend Additions and Accumulations**

a. **Additions**

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

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

b. **Accumulations**

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

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision (e.g., as set aside for burial), they are a countable resource.
6. Domestic Travel Tickets Gifts of domestic travel tickets [1612(b)(15)].

7. Victim’s Compensation Victim’s compensation provided by a state.

8. Tech-related Assistance Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].

9. $20 General Exclusion $20 a month general income exclusion for the unit.

   EXCEPTION: Certain veterans (VA) benefits are not subject to the $20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the $20 general exclusion.

10. PASS Income Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].

11. Earned Income Exclusions The following earned income exclusions are not deducted for the 300% SSI group:

   a. In 2006, up to $1,460 per month, but not more than $5,910 in a calendar year, of the earned income of a blind or disabled student child [1612(b) (1)].

   In 2007, up to $1,510 per month, but not more than $6,100 in a calendar year, of the earned income of a blind or disabled student child.

   b. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].

   c. $65 of earned income in a month [1612(b) (4)(C)].

   d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].

   e. One-half of remaining earned income in a month [1612(b) (4)(C)].

   f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

   g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. Child Support Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].
13. Native American Funds

The following Native American funds (only exclude for ABD MN groups):

a. Puyallup Tribe [ref. P.L. 101-41]
e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
g. Chippewas of Lake Superior [ref. P.L. 99-146]
h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
j. Wisconsin Band of Potowatomi [ref. P.L. 100-581]
k. Seminole Indians [ref. P.L. 101-277]
l. receipts from land distributed to:

- Pueblo of Santa Ana [ref. P.L. 95-498]
- Pueblo of Zia [ref. P.L. 95-499].

14. State/Local Relocation

State or local relocation assistance [1612(b) (18)].

15. USC Title 37 Section 310

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

M1460.620 RESERVED

M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS

A. Policy - Individual in An Institution for Less Than 30 Days

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of “institutionalization” is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the “institutionalization” definition.

B. Recipient

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

C. Applicant

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual’s income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual’s income eligibility.
M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. This post-eligibility treatment of income is called patient pay.

B. Policy

The state’s Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, ICF-MR or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services.

The DMAS-122 form shows the provider how much of the cost of care is paid by the patient (patient pay). The provider collects the patient pay from the patient or his authorized representative.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not affect the patient's Medicaid eligibility. However, if the patient pay is not paid to or collected by the provider, the EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

C. Patient Pay Definition

“Patient pay” is the amount of the LTC patient’s income which must be paid as his share of the LTC services cost. This amount is shown on the DMAS-122 to the provider and on the “Notice of Obligation for Long-Term Care Costs” to the patient.

D. Patient Pay Workbook and Worksheet

An electronic patient pay workbook and worksheet, including the DMAS-122, are available on the Virginia Institute for Social Services Training Activities (VISSTA) web site at: http://www.vcu.edu/vissta/bps/bps_resources/medicaid_worksheet.htm. While it is highly recommended that these tools be used to calculate patient pay, their use is not mandatory.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual’s eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual’s patient pay income using subsections B. and C. below.
B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a spouse or dependent child, or
- a deceased veteran’s surviving spouse who does not have a dependent child.

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a spouse or dependent child, or
- a deceased veteran’s surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including those patients who reside in the Veterans Care Center in Roanoke, Va.

2. Advance Payments To LTC Providers

Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay.

Advance payments which will not be refunded are usually made to reduce the recipient’s resources to the Medicaid limit.

C. Income Excluded As Patient Pay Income

All income listed in subchapter M1460.610 “What is Not Income” is not counted when determining patient pay, EXCEPT for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Other types of income excluded from patient pay are listed below.

1. SSI Payments

All SSI payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.

- If average interest income per month exceeds $10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments

Amounts withheld from monthly benefit payments to repay prior overpayments are not income for patient pay (the patient or his representative should be advised to appeal the withholding).
B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)
2. Dependent Child Allowance (M1470.420)
3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

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

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

1. Basic Maintenance Allowance


   Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic personal maintenance allowance.

   • EDCD Waiver,
   • MR Waiver,
   • Technology-Assisted Individuals Waiver
   • DD Waiver, and
   • DS Waiver

   Prior to September 1, 2006, the personal maintenance deduction is equal to the monthly SSI payment limit for one person (see M0810.002 A. 2.). Effective September 1, 2006, the personal maintenance deduction is equal to 165% of the monthly SSI payment limit for one person. The personal maintenance deduction is:

   • September 1, 2006 through December 31, 2006: $995
   • January 1, 2007 through December 31, 2007: $1028

   b. AIDS Waiver

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

2. Guardianship Fee

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

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

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

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

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

1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (see M0810.002 A. 3.) per month.

2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

The total amount of the personal maintenance allowance and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #9: (Using January 2005 figures)
A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of $928.80 per month and SSA of $300 monthly. His special earnings allowance is calculated by comparing his gross earned income ($ 928.80) to the 200% of SSI maximum ($ 1,158.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\[ \begin{align*} 
579.00 & \quad \text{CBC personal maintenance allowance} \\
+ 928.80 & \quad \text{special earnings allowance} \\
\hline
1,507.80 & \quad \text{total personal maintenance allowance} 
\end{align*} \]

B. Couples

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

The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held on the first moment of the first day of the first month of the first continuous period of institutionalization must be verified.

Verify all reported resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

4. Failure To Provide Verification

If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, “Notification Requirements.”

5. Processing Time Standard

A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

6. Completing the Medicaid Resource Assessment Form or Electronic Workbook

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to \( \frac{1}{2} \) of a couple's total countable resources as of 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.

a. Compile the Couple’s Resources

The value of countable resources must be verified and recorded. Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used. The workbook is located on the Virginia Institute for Social Services Training Activities (VISSTA) web site at:

http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm

Excluded resources must be listed separately on the form or electronic workbook, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest - resources in their joint names, those in the institutionalized spouse's name and those in the community spouse’s name, including those resources owned jointly with others. List each resource separately.
b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is \( \frac{1}{2} \) of the couple's combined countable resources as of 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.

Calculate the spousal share only once; it remains a constant amount for any Medicaid application filed after the resource assessment.

**EXAMPLE #2:** A Medicaid Resource Assessment Request is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the first month of the first continuous period of institutionalization) were $131,000. The spousal share is \( \frac{1}{2} \) of $131,000, or $65,500.

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

<table>
<thead>
<tr>
<th>Resource</th>
<th>Owner</th>
<th>Countable</th>
<th>Countable Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Mr &amp; Mrs</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Savings</td>
<td>Mr &amp; Mrs</td>
<td>Yes</td>
<td>$100,000</td>
</tr>
<tr>
<td>CD</td>
<td>Mr</td>
<td>Yes</td>
<td>$31,000</td>
</tr>
</tbody>
</table>

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

$ 65,500 Spousal Share

If in the future, Mrs. H applies for Medicaid and she is still married to Mr. H, the worker must use the spousal share of $65,500 determined by the October 1996 resource assessment.

7. **Send Loans and/or Judgments to DMAS**

When the resource assessment identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the resource assessment. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

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

8. **Notification Requirements**

a. **When the Assessment Is Not Completed**

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).
b. When the Assessment Is Completed

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

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

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

B. Policy

1. Resource Assessment

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

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

2. Use ABD Resource Policy

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

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received before 11/01/05, exclude from resources for six (6) calendar months; and
- up to $1,500 of burial funds for each spouse (NOT $3,500).
Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

C. Appeal Rights
When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility
Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple on the first moment of the first day of the first month of the first continuous period of institutionalization,
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures
The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms
The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization. The workbook is located on the VISSTA web site at:

a. Compile the Couple’s Resources

The value of countable resources must be verified and recorded on the Medicaid Resource Assessment form (#032-03-816) or electronic workbook. Excluded resources must be listed separately on the form, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest - resources in their joint names, those in the institutionalized spouse's name and those in the community spouse’s name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple’s countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's total countable resources as of 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.

Calculate the spousal share only once; it remains a constant amount for the current Medicaid application and all subsequent Medicaid applications filed.

EXAMPLE #3: A Medicaid application is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Neither she nor her spouse requested a resource assessment before applying for Medicaid.

To determine Mrs. H's eligibility and the amount of the couple's current resources that can be "protected" for Mr. H, Mr. H provides verification which proves that the couple’s total countable resources as of December 1, 1995 (the first day of the beginning of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.
On the Medicaid Resource Assessment form or electronic workbook, the worker lists the couple's resources as of December 1, 1995 as follows:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Owner</th>
<th>Countable</th>
<th>Countable Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Mr &amp; Mrs</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Savings</td>
<td>Mr &amp; Mrs</td>
<td>Yes</td>
<td>$100,000</td>
</tr>
<tr>
<td>CD</td>
<td>Mr</td>
<td>Yes</td>
<td>$31,000</td>
</tr>
</tbody>
</table>

$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 owned as of the first moment of the first day of the month for which eligibility is being determined 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 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.

1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, regardless of the individual's covered group and regardless of community property laws or division of marital property laws, except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:
• the home and all contiguous property;
• one automobile, regardless of value;
• Disaster Relief funds for 9 months;
• retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
• up to $3,500 of burial funds for each spouse.

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

2. After Eligibility is Established

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

C. “Institutionalized Spouse Resource Eligibility Worksheet”

Use the “Institutionalized Spouse Resource Eligibility Worksheet” (M1480, Appendix 4) or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm to determine the institutionalized spouse’s resource eligibility.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

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

B. Spousal Resource Standard

$20,328  1-1-07
$19,908  1-1-06

C. Maximum Spousal Resource Standard

$101,640  1-1-07
$99,540  1-1-06

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.
a. Not Eligible In Initial Eligibility Determination Period

If the institutionalized spouse is NOT eligible after deducting the spousal PRA from the couple's total resources, DO NOT USE this section. Go to section M1480.250 below when resources exceed the limit.

b. Eligible In Initial Eligibility Determination Period

When the institutionalized spouse's countable resources (as calculated in section M1480.232 above) are within the Medicaid resource limit, calculate the CSRA using the policy and procedures in section M1480.241.

2. Subsequent Application

a. Medicaid Eligibility Never Established

If an individual has applied before but never established Medicaid eligibility as an institutionalized spouse and is NOT eligible in the initial eligibility determination period, DO NOT USE THIS SECTION. Go to section M1480.250 below.

b. Medicaid Eligibility Established Previously

Once an institutionalized spouse has established initial 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.

When determining the institutionalized spouse's eligibility based on any application made after having previously established Medicaid eligibility as an institutionalized individual, 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 in the application month and the application's retroactive month(s). Do not calculate a CSRA; there is no protected period of eligibility. Go to section M1480.255 below.

M1480.241 CSRA CALCULATION PROCEDURES

A. Worksheet

Use the “Institutionalized Spouse Resource Eligibility Worksheet” (M1480, Appendix 4) or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm to determine countable resources and the CSRA.

B. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established.

C. Determine Institutionalized Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources owned as of the first moment of the first day of the
initial month for which eligibility was established. If the institutionalized spouse’s resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse’s resources owned as of the first moment of the first day of the month following the initial month.

D. Calculate the Community Spouse Resource Allowance (CSRA)

To calculate the CSRA:

1. **PRA**
   
   Find the spousal PRA (determined in section M1480.232 above).

2. **Subtract Resources**
   
   Subtract the community spouse's owned as of the first moment of the first day of the initial month in which eligibility was established.

3. **Remainder**
   
   The remainder, if greater than zero, is the CSRA (community spouse resource allowance).

   If the remainder is $0 or a negative number, the CSRA = $0. The community spouse does not have a CSRA.

E. Subtract the CSRA

Find the CSRA calculated in D above.

Subtract the CSRA from the institutionalized spouse's resources owned effective the first moment of the first day of the initial month in which initial eligibility is established.

The remainder is the institutionalized spouse's countable resources for the month following the initial month in which eligibility is established.

F. Countable Resources Less Than or Equal To the Resource Limit

If the countable resources are less than or equal to the Medicaid resource limit, the institutionalized spouse remains eligible for a protected period of time if he expresses in writing the intent to transfer an amount of his resources, equal to the CSRA, to the community spouse. See section M1480.242 below.

G. Countable Resources Exceed Resource Limit

If the countable resources exceed the Medicaid resource limit, the institutionalized spouse is not eligible for Medicaid; deny eligibility for the months following the initial month in which eligibility is established. Go to section M1480.250 below.

H. Example--CSRA Calculation

**EXAMPLE #9:** Mrs. Tea applied for Medicaid on May 21, 1998. She was admitted to the nursing facility on December 20, 1997. She is married to Mr. Tea who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1997. Eligibility is being determined for May 1998.

**Step 1:**

The couple's total countable resources as of December 1, 1997 (the first moment of the first day of the first continuous period of institutionalization) were $50,000.
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. Aid Category

   a. If the institutionalized spouse does NOT have Medicare Part A:

   - Aged = 018
   - Blind = 038
   - Disabled = 058
   - Child Under 21 in ICF/ICF-MR = 098
   - Child Under Age 18 = 088
   - Juvenile Justice Child = 085
   - Foster Care/Adoption Assistance Child = 086
   - Pregnant Woman = 097

   b. If the institutionalized spouse has Medicare Part A:

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

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

   - Aged = 028
   - Blind = 048
   - Disabled = 068

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

   - Aged = 018
   - Blind = 038
   - Disabled = 058

3. Patient Pay

   Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications

   The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.
After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

**M1480.400 PATIENT PAY**

**A. Introduction**

This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.

**B. Married With Institutionalized Spouse in a Facility**

For a married LTC patient with an institutionalized spouse in a facility, NO amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

**M1480.410 MAINTENANCE STANDARDS & ALLOWANCES**

**A. Introduction**

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

**B. Monthly Maintenance Needs Standard**

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<td>$1,603.75</td>
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**C. Maximum Monthly Maintenance Needs Allowance**

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<td>$2,488.50</td>
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**D. Excess Shelter Standard**

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<tr>
<td>$481.13</td>
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**E. Utility Standard Deduction (Food Stamps)**

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<td>$281</td>
<td>1 - 3 members</td>
<td>10-1-06</td>
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<tr>
<td>$352</td>
<td>4 or more</td>
<td>10-1-06</td>
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<tr>
<td>$253</td>
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<tr>
<td>$317</td>
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<td>2-1-06</td>
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**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).
B. What Is Patient Pay

The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse’s and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.

C. Dependent Allowances

A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then NO allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.

D. Home Maintenance Deduction

A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is NOT allowed the home maintenance deduction because the community spouse allowance provides for the home maintenance, UNLESS:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
- the institutionalized spouse still needs to maintain their former home.

E. Patient Pay Workbook and Worksheet

An electronic patient pay workbook and worksheet, including the DMAS-122, are available on the VISSTA web site at: http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm. While it is highly recommended that these tools be used to calculate patient pay, their use is not mandatory.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

A. Patient Pay Gross Monthly Income

Determine the institutionalized spouse’s patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 B.1 for both covered groups.

B. Subtract Allowable Deductions

If the patient has no patient pay income, he has no patient pay deductions.

When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

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

C. Personal Needs or Maintenance Allowance

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

1. Facility Care

a. Basic Allowance

Deduct the $30 basic allowance.

b. Guardian Fee

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

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

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

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

c. Special Earnings Allowance

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

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

The special earnings allowance cannot exceed $190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of $875 per month. His special earnings allowance is calculated first:
$875  gross earned income
-  75  first $75 per month
  800  remainder
\[ \div 2 \]
  400  \( \frac{1}{2} \) remainder
\[ \div 75 \]
  75  first $75 per month
$475  which is \( > \) $190

His personal needs allowance is calculated as follows:

$  30.00 basic personal needs allowance
+190.00 special earnings allowance
+  17.50 guardianship fee (2% of $875)
$237.50 personal needs allowance

2. Medicaid CBC Waiver Services

a. Maintenance Allowance

Deduct the appropriate maintenance allowance for one person, based on the specific Medicaid CBC waiver under which the individual receives LTC services:

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

   • Prior to September 1, 2006, the personal maintenance allowance is equal to the monthly SSI payment limit for one person *(see M0810.002 A. 2).*

   • Effective September 1, 2006, the personal maintenance allowance is 165% of the monthly SSI payment for one person, *which is:*

     - *September 1, 2006 through December 31, 2006:* $995
     - *January 1, 2007 through December 31, 2007:* $1028

2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person *(see M0810.002 A. 3.).*

b. Guardian Fee

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

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

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

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.
c. Special Earnings Allowance For DD, DS and MR Waivers

EXAMPLE #19: (deleted)

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

a) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI per month.

b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

EXAMPLE #20: (Using January 2000 figures)

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

\[
\begin{align*}
\text{gross earned income} & \quad 928.80 \\
- \text{200\% SSI maximum} & \quad 1,024.00 \\
\text{remainder} & \quad 0 \\
\end{align*}
\]

$928.80 = \text{special earnings allowance}

His personal maintenance allowance is calculated as follows:

\[
\begin{align*}
\text{maintenance allowance} & \quad 512.00 \\
+ \text{special earnings allowance} & \quad 928.80 \\
\text{personal maintenance allowance} & \quad 1,440.80 \\
\end{align*}
\]
D. Community Spouse Monthly Income Allowance

The community spouse monthly income allowance is the difference between the community spouse's gross monthly income and the minimum monthly maintenance needs allowance determined below.

1. Determine Minimum Monthly Maintenance Needs Allowance (MMMNA)

   Calculate the minimum monthly maintenance needs allowance using the following procedures (do NOT round any cents to a dollar):
   
   a. the monthly maintenance needs standard, plus
   
   b. an excess shelter allowance for the community spouse's principal place of residence, if applicable. The excess shelter allowance is the amount by which the total of verified allowable expenses in 1) through 5) below exceeds the excess shelter standard.

   Allowable expenses are:

   1) rent,
   2) mortgage (including interest and principal),
   3) taxes and insurance,
   4) any maintenance charge for a condominium or cooperative, and
   5) the utility standard deduction, unless utilities are included in the community spouse's rent or maintenance charges.

   The utility standard deduction for a household of 1-3 members is different than the deduction for households of 4 or more members.

2. Maximum Allowance

   The minimum monthly maintenance needs allowance calculated above cannot exceed the maximum.

3. Court or DMAS Hearing Officer Ordered Amount

   If a court support order requires support in an amount that is greater than the minimum monthly maintenance needs allowance calculated above, or if a DMAS Hearing Officer has determined that an amount greater than the one calculated above is needed because of exceptional circumstances resulting in extreme financial duress, DO NOT use the procedures in D.1. and D.2. above for the minimum monthly maintenance needs allowance, and do not calculate the community spouse monthly income allowance. The community spouse monthly income allowance is the amount designated by the court order or the DMAS Hearing Officer.
4. **Calculate Community Spouse Monthly Income Allowance**

If no court order or DMAS Hearing Officer determination of the monthly maintenance needs allowance exists, use the following procedures to calculate the community spouse monthly income allowance:

#### a. Determine Gross Monthly Income

Determine the community spouse's gross monthly income using the income policy in section M1480.310. Do not count any payment that is made to the community spouse by the institutionalized spouse, such as the community spouse's portion of an augmented VA benefit which is included in the institutionalized spouse's VA check. This amount will be counted in the institutionalized spouse's income.

#### b. Subtract From MMMNA

Subtract the community spouse's gross income from the minimum monthly maintenance needs allowance from D.1. above. **Do NOT round any cents to a dollar.** The remainder is the community spouse monthly income allowance (a negative number equals $0).

#### c. Remainder Greater Than $0

If the remainder is greater than $0, the remainder is the amount of the community spouse monthly income allowance that is deducted from the institutionalized spouse’s patient pay.

#### d. Remainder Less Than or Equal To $0

If the remainder is $0 or less, the community spouse monthly income allowance is $0.

5. **Deduct From Patient Pay**

Deduct the community spouse monthly income allowance determined above from the institutionalized spouse's patient pay income UNLESS the institutionalized spouse or his authorized representative does not actually make it available to the community spouse or to another person for the benefit of the community spouse.
EXAMPLE #21: (Using January 2000 figures)

A community spouse has $800 per month gross income; $600 from Civil Service and $200 VA pension. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $439 per month, plus the standard utility allowance of $168 for a household of one person, totaling $607. Total shelter costs of $607 exceed the excess shelter standard of $415 by $192. The excess shelter allowance is $192.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

\[
\begin{align*}
\$1,383.00 & \quad \text{monthly maintenance needs standard} \\
+ & \quad 192.00 \quad \text{excess shelter allowance} \\
\$1,575.00 & \quad \text{MMMNA (less than maximum)}
\end{align*}
\]

The community spouse monthly income allowance is calculated:

\[
\begin{align*}
\$1,575.00 & \quad \text{MMMNA} \\
- & \quad 800.00 \quad \text{community spouse's monthly gross income} \\
\$775.00 & \quad \text{community spouse monthly income allowance}
\end{align*}
\]

The institutionalized spouse has monthly income of $1,100. However, he refuses to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance cannot be deducted. His patient pay is calculated:

\[
\begin{align*}
\$1,100 & \quad \text{gross income} \\
- & \quad 30 \quad \text{personal needs allowance} \\
\$1,070 & \quad \text{patient pay}
\end{align*}
\]

EXAMPLE #22: (Using January 2000 figures)

A community spouse has $900 per month gross income from Social Security. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $502 per month, plus the standard utility allowance of $168 for a household of one person, totaling $670. Total shelter costs of $670 exceed $415 by $255. The excess shelter allowance is $255.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

\[
\begin{align*}
\$1,383 & \quad \text{monthly maintenance needs standard} \\
+ & \quad 255 \quad \text{excess shelter allowance} \\
\$1,638 & \quad \text{MMMNA}
\end{align*}
\]
The community spouse monthly income allowance is calculated:

\[ \text{\$1,638 MMMNA} \]
\[ - \text{\$900 community spouse's gross income} \]
\[ \text{\$738 community spouse monthly income allowance} \]

The institutionalized spouse has monthly income of \$700. He agrees to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance is deducted. His patient pay is calculated:

\[ \text{\$700 gross patient pay income} \]
\[ - \text{\$30 personal needs allowance} \]
\[ \text{\$670 remainder} \]
\[ - \text{\$670 community spouse income allowance} \]
\[ \text{\$0 patient pay} \]

NOTE: The community spouse monthly income allowance of \$738 is greater than the income remaining after the personal needs allowance is deducted, so only \$670 is deducted from patient pay for the community spouse monthly income allowance.

E. Family Member's Income Allowance

To be eligible for a family member’s income allowance, the family member (as defined in section M1480.010) must live with the community spouse.

1. Minor Child NOT Living With Community Spouse

If an institutionalized spouse has a minor child who is not living with the community spouse, no allowance is calculated for that child and no deduction from the institutionalized spouse’s income is made for that child.

2. Family Member Income Allowance Deductions

The family member income allowance is an amount equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the amount of the family member's gross monthly income: 

\[ \text{(maintenance needs standard - family member's income)} \div 3 = \text{family member's income allowance}. \]

First, deduct the allowance(s) for minor child(ren) living with the community spouse in the home. Deduct other family members’ allowances from patient pay after deducting the minor child(ren)’s allowance(s).

3. Calculate Family Member's Allowance

Calculate each family member’s allowance as follows:

a. Subtract the family member's gross monthly income from the monthly maintenance needs standard. If the remainder is \$0 or less, STOP. The family member is not entitled to an allowance.

b. Divide the remainder by 3.

c. The result is the family member's monthly income allowance. Do NOT round any cents to a dollar.
# TABLE OF CONTENTS

## M15 ENTITLEMENT POLICY & PROCEDURES

### M1510.000 MEDICAID ENTITLEMENT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Entitlement</td>
<td>1</td>
</tr>
<tr>
<td>Retroactive Eligibility &amp; Entitlement</td>
<td>1</td>
</tr>
<tr>
<td>Ongoing Entitlement</td>
<td>5</td>
</tr>
<tr>
<td>Disability Denials</td>
<td>8</td>
</tr>
<tr>
<td>Foster Care Children</td>
<td>8</td>
</tr>
<tr>
<td>Delayed Claims</td>
<td>9</td>
</tr>
<tr>
<td>Notice Requirements</td>
<td>9</td>
</tr>
<tr>
<td>Follow-Up Responsibilities</td>
<td>11</td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td>11</td>
</tr>
<tr>
<td>Social Security Numbers</td>
<td>14</td>
</tr>
<tr>
<td>Patient Pay Notification</td>
<td>15</td>
</tr>
<tr>
<td>Newborns of Emergency-Services-Only Aliens</td>
<td>16</td>
</tr>
</tbody>
</table>
M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month. However, if the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.

B. SSI Entitlement

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.

C. Procedures

The procedures for determining an eligible individual’s Medicaid coverage entitlement are contained in the following sections:

- M1510.101 Retroactive Eligibility & Entitlement
- M1510.102 Ongoing Entitlement
- M1510.103 Disability Denials
- M1510.104 Foster Care Children
- M1510.105 Delayed Claims

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be CN, CNNMP or MI in one or two months and MN in the third month, or any other combination of classifications.

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual’s covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

*If the applicant reports receipt of a hospital service within the month immediately preceding the application month, the application date is within 30 days of the hospital service, and the applicant is not eligible for retroactive Medicaid, the applicant’s eligibility for SLH must be determined.*
When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

C. Budget Periods By Classification

1. CN, CNNMP, MI

   The retroactive budget period for categorically needy (CN), categorically needy non-money payment (CNNMP) and medically indigent (MI) covered groups (categories) is one month.

   CN, CNNMP or MI eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

   NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. Medically Needy (MN)

   In the retroactive period, the **MN budget period is always all three months** in the retroactive period. Unlike the CN, CNNMP or MI, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN, CNNMP or MI.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN, CNNMP or MI retroactive coverage for those months.

**EXAMPLE #1:** Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation; she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for MI Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.
1. **Excess Income In One or More Retroactive Months**

   When an applicant has excess income in one or more of the retroactive months, he must verify that he met the nonfinancial and resource requirements in the month(s). He must verify the income he received in all 3 retroactive months in order to determine his MN income or spenddown eligibility in the retroactive month(s).

   If he fails to verify income in all three months, he CANNOT be eligible as medically needy in the retroactive period. His application for the retroactive months in which excess income existed must be denied because of failure to provide income verification for that month(s). However, coverage for the retroactive month(s) in which he was eligible as CNNMP or MI must be approved.

**EXAMPLE #2: (Using July 2006 figures)**

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in February. She also has unpaid medical bills (old bills) from December. The retroactive period is January - March.

The eligibility worker determines that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that the countable income of $3,250 per month in January and February exceeded the F&C, MI and the MN income limits. The income of $800 starting March 1 is within the F&C MI income limit. The parent verifies that the resources in January, February were within the MN resource limit, but does not verify the March resources because the income is within the MI income limits.

The application is approved for retroactive coverage as MI beginning March 1 and for ongoing coverage beginning April 1. The child’s spenddown liability is calculated for January and February. The eligibility worker deducts the old bills and the incurred medical expenses, and a spenddown liability remains. The retroactive Medicaid coverage is denied for January and February because the spenddown was not met.

2. **Excess Income In All 3 Retroactive Months**

   When excess income existed in all classifications in all 3 retroactive months, the applicant must verify that he met all eligibility requirements in all 3 months. If he fails to verify nonfinancial, resource or income eligibility in any of the retroactive months, the retroactive period cannot be shortened and he CANNOT be placed on a retroactive spenddown. His application for retroactive coverage must be denied because of excess income and failure to provide eligibility verification for the retroactive period.

**EXAMPLE #3: (Using July 2006 figures)**

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in March. The retroactive period is January – March.
The worker verifies that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that their countable income of $3,250 in January, February and March exceeded the F&C MI and the MN income limits. The worker verifies that their resources in January and February were within the MN resource limits, but is unable to verify the resources for March.

The application is denied for retroactive coverage as MI Medicaid because of excess income and denied for MN spenddown because of failure to provide resource verification for all months in the retroactive period.

E. Disabled Applicants

If the applicant was not eligible for SS or SSI disability benefits during the retroactive period and the recipient alleges he/she was disabled during the retroactive period, follow the procedures in M0310.112 for obtaining an earlier disability onset date.

F. Excess Resources in Retroactive Period

If the applicant had excess resources during part of the retroactive period, retroactive resource eligibility exists only in the month(s) during which the resources were at or below the limit at any time within the month. The applicant's eligibility must be denied for the month(s) during which excess resources existed during the entire month.

EXAMPLE #4: (Using July 2006 figures)

Mr. A applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month; no hospital service was received. The retroactive period is April 1 through June 30. He currently receives SS disability benefits of $1500 per month and received SS disability of $1500 monthly during the retroactive period. He is not eligible for Medicare Part A. His verified resources exceeded the MN limit in April and part of May; the resources were reduced to below the MN limit on May 20. He met the retroactive spenddown on April 5. His application was approved for retroactive MN coverage beginning May 1, and April coverage was denied because of excess resources.

G. Income Determination

Countable income for the applicant's unit is that income which was actually received in the three months prior to the application month.

1. Monthly Determination for CN/CNNMP & MI

When an individual in the family unit meets a CN, CNNMP or MI covered group, compare each month's countable income to the appropriate CN/CNNMP or MI income limit for the month. When the countable income is within the CN, CNNMP or MI income limit in the month, the CN, CNNMP or MI individual meets the income eligibility requirement for that retroactive month. Enroll the eligible CN, CNNMP or MI unit member(s) for that month(s) only, using the appropriate CN, CNNMP or MI covered group program designation.

2. Medically Needy (MN)

When the family unit's countable income exceeds the CN, CNNMP or MI income limit in one or more of the retroactive months, and all other
Medicaid medically needy eligibility factors are met in that month(s), determine if the unit meets the MN income limit for the 3-month retroactive budget period.

When the unit's countable income exceeds the MN limit for 3 months, place the unit on a spenddown for the month(s) in which excess income existed. See subchapter M1330 for retroactive spenddown eligibility determination policy and procedures.

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met.

NOTE: A QMB is never eligible for retroactive coverage as a QMB-only.

The applicant is entitled to Medicaid coverage for only the month(s) in which all eligibility factors were met. If all factors except income were met in all the retroactive months, then the applicant is placed on spenddown for the retroactive period. See subchapter M1330 to determine retroactive spenddown eligibility.

1. Retroactive Coverage Begin Date

If the applicant is eligible for retroactive coverage, he is enrolled effective the first day of the month in which he met all eligibility factors. When excess income existed in a retroactive month(s), entitlement begins the date the retroactive spenddown was met.

2. Retroactive Coverage End Date

The Medicaid recipient's retroactive Medicaid coverage expires after the last day of the retroactive month(s) in which he was entitled to Medicaid.

3. Example

EXAMPLE #5: Mr. B applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He met all eligibility requirements in the retroactive period. He is entitled to retroactive Medicaid coverage beginning April 1 and ending June 30.

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

Ongoing Medicaid entitlement for all covered groups except the medically indigent Qualified Medicare Beneficiary (QMB) group begins the first day of the application month when all eligibility factors are met at any time in the month of application. Exceptions:

- when an applicant has excess income;
- when the applicant is eligible only as a medically indigent qualified Medicare beneficiary (QMB); or
- when the applicant is age 21-64 years and is admitted to an institution for treatment of mental diseases (IMD).
1. Applicant Has Excess Income

When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.

2. QMB Applicant

Entitlement to Medicaid for a medically indigent Qualified Medicare Beneficiary (QMB) begins the first day of the month following the month in which the individual's QMB eligibility is determined.

3. SLMB and QDWI

Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) MI covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.

4. Applicant Age 21-64 Is Admitted To Ineligible Institution

An applicant who is age 21-64 years and who is admitted to an IMD or other ineligible institution (such as a jail) in a month is NOT eligible for Medicaid while he is a patient in the IMD (or is residing in the ineligible institution). If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

**EXAMPLE #6:** Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, 2006. He receives Social Security disability benefits. He was admitted to Central State Hospital (an IMD) on October 20, 2006, and was discharged on November 2, 2006, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2006 and ongoing, except for the period of time he was in Central State Hospital. The worker enrolls him in Medicaid for a closed period of coverage beginning October 1, 2006, and ending October 20, 2006. The worker also enrolls him in an ongoing period of Medicaid coverage beginning November 2, 2006.

5. Applications From CSBs For IMD Patients Ages 21-64 Years

A patient who is age 21 years or older but is less than 65 years and who is in an institution for treatment of mental diseases (IMD) is not eligible for Medicaid while in the IMD. Local agencies will take the applications received from the CSBs for DMHMRSAS IMD patients who will be discharged within 30 days and process the applications within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD. If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

**EXAMPLE #6a:** Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends
his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is an MI pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution (see below).

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. MI Pregnant Woman

For an eligible MI pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

Following the end of the postpartum period, the MI pregnant woman continues to be eligible for Medicaid in the Family Planning Services (see M0320.302) covered group for 10 months (12 months following the end of the pregnancy) regardless of any change in income.

2. Individual Age 21-64 Admitted to Ineligible Institution

For an eligible Medicaid enrollee age 21-64 years, entitlement to Medicaid ends on the date following the date he is admitted to an IMD or other ineligible institution. Cancel coverage as soon as possible after learning of the enrollee’s admission to an ineligible institution. Cancel coverage in the MMIS effective the date the cancel action is taken, using cancel reason code “008.” Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

3. Spenddown Enrollees

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual’s or family’s circumstances change before that date.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or
below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

A. Policy
When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

1. Subsequent SSA/SSI Disability Decisions
The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application. The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is within 90 days of the application. If the re-evaluation determines that the individual is eligible, entitlement is based on the date of the Medicaid application and the disability onset date. If the denied application is more than 12 months old, a redetermination using current information must also be completed.

M1510.104 FOSTER CARE CHILDREN

A. Policy
Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

B. Retroactive Entitlement
If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the
retroactive period. If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.

M1510.105 DELAYED CLAIMS

A. When Applicable Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the delayed filing was a delay in the enrollee’s eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the enrollee is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements The letter must:

- be on the agency's letterhead stationery and include the date completed.
- be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."
- state the enrollee's name and Medicaid recipient I.D. number.
- state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures The “eligibility delay” letter and a sufficient number of copies must be given to the enrollee to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. If the date the letter was prepared by the agency is not included on the letter, the claim will be denied. A sample eligibility delay letter is available on the local agency intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

M1510.200 NOTICE REQUIREMENTS

A. Policy Federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

The agency must provide the information required above at the time of any action affecting his claim for Medicaid benefits.
B. Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs

The "Notification of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.
- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing his application.
- of the status of his request for reevaluation of his application in spenddown status.

When the application was filed by the applicant’s authorized representative, a copy of the notification must be mailed to the applicant’s authorized representative.

1. MI Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice ("Notification of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs") must state the reason for denial. The notice must also include the "Application For Benefits" form and must advise the applicant of the following:

a. that he/she may complete and file the enclosed application for Medicaid spenddown, and

b. if he/she files the application (Application For Benefits) within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB’s) application for medically indigent Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for Medicaid because of excess resources.

b. Excess income

1) If the QMB's resources are within the medically indigent limit but are over the medically needy limit, and the income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for
medically needy spenddown because of excess resources. The notice must specify the dollar amount of the appropriate medically needy resource limit.

2) If the QMB's resources are within the medically needy limit, and income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for Medicaid because of excess income, but that the applicant can spenddown his/her income to become eligible. The notice must specify the spenddown amount, the spenddown period begin and end dates, and should include information about how spenddown works (such as the "Virginia Medicaid Handbook" or the spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

There are instances when an applicant is not eligible for ongoing Medicaid coverage but is eligible for retroactive benefits, or when a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time.

Only one "Notification of Action on Medicaid" (Form 032-03-008) is sent to the applicant covering both actions. Statements of the exact dates of Medicaid coverage entitlement, the date entitlement ends, and the reason(s) for ineligibility must be included on this notice.

**Example #7:** An application for Medicaid is filed on December 5. The agency takes action on this application in February. The client was determined eligible for Medicaid effective December 1 and through January. Because of his inheritance of real property on January 30 which exceeds the resource limit, he is ineligible for ongoing benefits after January 31. One notice is sent to the applicant stating that his Medicaid application was approved with Medicaid coverage beginning December 1 and ending January 31, and that he is denied coverage after January 31 because of excess resources (real property).

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

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

B. Private Health Insurance

Information on private health insurance coverage must be obtained and recorded in the eligibility record and the computer TPL file. This must include the company name (code number for the TPL file), the policy number, and the beginning date of the policy coverage. Health insurance policy or coverage changes which occur after application must be updated in the eligibility record and TPL file.

If a member of the assistance unit is employed more than 30 hours per week, the HIPP Application and Medical History Questionnaire must be sent to the HIPP Unit at DMAS. See the HIPP requirements in M0290.
C. Medicare

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

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

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

1. Buy-In Procedure

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

2. Medicare Claim Numbers

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

a. SSA claim numbers consist of a nine-digit number followed by a letter, or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.

b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

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

b. Applicants Who Cannot Produce a Claim Number

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

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

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

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

<table>
<thead>
<tr>
<th>Classifications</th>
<th>Buy-in Begin Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category Needy Cash Assistance</td>
<td>1st month of eligibility</td>
</tr>
<tr>
<td>ABD MI (includes dually-eligible)</td>
<td>1st month of eligibility</td>
</tr>
<tr>
<td>Categorically Needy Non-money Payment and Medically Needy who are dually-eligible (countable income ≤ 100% FPL and Medicare Part A)</td>
<td>1st month of eligibility</td>
</tr>
<tr>
<td>Categorically Needy Non-money Payment and Medically Needy who are not dually-eligible (countable income &gt; 100% FPL or no Medicare Part A)</td>
<td>3rd month of eligibility</td>
</tr>
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If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.
D. Other Third Party Liability

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

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

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

E. Pursuing Third Party Liability and Medical Support

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

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

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

1. Exceptions

An SSN or application for an SSN are not required for the following individuals:

- Children under age one born to Medicaid-eligible mothers, as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together; and

- Illegal aliens who are eligible only for Medicaid payment of emergency services (see M0220).

2. Application for SSN Required

If the applicant does not have an SSN, he must cooperate in applying for such a number with the local Social Security Administration Office (SSA). An Enumeration Referral Form, form #032-03-400, available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi must be completed by the applicant.

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.
B. Procedures

1. Documentation

If the applicant does not have a Social Security number, the agency must document in the record when he/she has applied for an SSN.

*When entering the individual in ADAPT or MedPend, use the date the individual applied for an SSN, or the individual’s date of birth, preceded by “APP.” For example, an individual applied for an SSN on October 13, 2006. Enter “APP101306” as the individual’s SSN.*

2. Follow-up

The agency must follow-up this action within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

- document the recipient's assigned Social Security number in the case record,
- enter the recipient’s Social Security number on the MMIS computer recipient eligibility file, and in ADAPT if the enrollee is in ADAPT.

3. Renewal Action

   a. At renewal, check the MMIS and ADAPT records for the enrollee’s SSN. If the SSN has “888” or “APP” as the first 3 digits, contact the enrollee to obtain the enrollee’s SSN verbally, by mail or email, or on the renewal form if a renewal form is required.

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

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

M1510.303 PATIENT PAY NOTIFICATION

A. Policy

After an individual in long-term care is found eligible for Medicaid, the recipient’s patient pay must be determined. When the patient pay amount is initially established or when it is changed, a written notice must be sent to the recipient or the recipient's authorized representative.

B. Procedure

When patient pay is determined, the "Notice of Obligation for Long-Term Care Costs" form must be sent. For any subsequent decrease in patient pay, the form will serve as adequate notice.

When patient pay increases, the "Notice of Obligation for Long-Term Care Costs" form must be sent in advance of the date the new amount is effective. Following the advance notice period, the new DMAS-122 is released to the provider, if an appeal was not filed.
NEWBORNS OF EMERGENCY-SERVICES-ONLY ALIENS

A. Initial Enrollment Policy

Newborn children born to emergency services alien women who are determined eligible for Medicaid payment of emergency services only must have an application filed on their behalf. The newborn’s mother must be determined eligible for and enrolled in Medicaid effective the date of the child’s birth. Eligibility verifications for the newborn are postponed until after initial enrollment. See section M0130.200 B. for the detailed initial enrollment policy.

B. Follow-up Procedures

1. Notify Applicant of Required Verification

After initial enrollment, the EW must send a letter to the child’s parent(s) requesting:

- proof of application for the child’s Social Security number,
- identity documentation for the child, and
- verification of income for household members, including the child’s father if he resides in the home and is not married to the child’s mother.

Do NOT request the child’s birth verification from the parent(s).

2. Request Birth Verification from VDH

Eligibility workers must request birth record verification (citizenship documentation) for these children directly from the Virginia Department of Health (VDH) Office of Vital Records without first requesting it from the parent. Birth record information will be available through the Office of Vital Records approximately 15 days after the baby’s birth.

Please review the procedures document titled “Important Reminders When Requesting Birth Record Verification from VDH” posted on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/procedures.cgi BEFORE sending requests to VDH.

3. Procedures - Requests to VDH

Use the following procedures for requesting the birth verification:

a. Complete the form “Application for Confidential Verification of Birth” available at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0283-00-eng.doc. This form provides client information necessary for VDH to conduct a match of its vital records birth certificate information and is to be filled out as accurately and completely as possible.

b. Using the coversheet http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0285-00-eng.doc, requests can be sent to: Office of Vital Records, Virginia Department of Health, P.O. Box 1000, Richmond, Virginia 23218-1000, Attention: Janet Rainey, Director of Vital Records, marked “Medicaid Request.” Include a self-addressed return envelope with the names of the agency and the authorized individual.
Agency requests for VDH birth certificate verification should be “batched” (i.e. compiled together) and sent in a batch rather than sent individually to VDH on a routine basis. The request cover sheet must be signed by the staff person who was authorized by the LDSS to request and receive the VDH birth certification. See the Citizenship and Identity Procedures document section D for detailed instructions; the document is on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/procedures.cgi.

4. **Identity Verification**

If the application form signed by the parent has been amended to include language documenting identity for children under age 16, no additional identity documentation will be needed. If documentation of identity is needed, send the parent the Affidavit of Identity for a Child Under the Age of 16 form at the time the letter requesting income and Social Security number or proof of application for the SSN is sent.

C. **Agency Action Following Request For Information**

1. **Action Taken If Necessary Documents Not Received**

   If the necessary information is not received within the time frame stated in the notice to the parent(s), coverage in Medicaid MUST be terminated effective the end of the month following the expiration of the 10-day advance notice period.

2. **Action Taken If Child Determined Ineligible For Medicaid**

   If the information is received and the child is not Medicaid-eligible, coverage in Medicaid MUST be terminated effective the end of the month following the expiration of the 10-day advance notice period. Children with countable income in excess of Medicaid limits should be evaluated for FAMIS eligibility and must be offered an opportunity to apply for a medically needy spenddown evaluation if income is over the FAMIS income limits.
# TABLE OF CONTENTS

## M15 ENTITLEMENT POLICY & PROCEDURES

### M1520.000 MEDICAID ELIGIBILITY REVIEW

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Principle</td>
<td>1</td>
</tr>
<tr>
<td>Partial Review</td>
<td>1</td>
</tr>
<tr>
<td>Renewal Requirements</td>
<td>3</td>
</tr>
<tr>
<td>Medicaid Cancellation or Services Reduction</td>
<td>8</td>
</tr>
<tr>
<td>Notice Requirements</td>
<td>8</td>
</tr>
<tr>
<td>Cancellation Action/Services Reduction</td>
<td>10</td>
</tr>
<tr>
<td>Recipient Requests Cancellation</td>
<td>10</td>
</tr>
<tr>
<td>Extended Medicaid Coverage</td>
<td>11</td>
</tr>
<tr>
<td>Four Month Extension</td>
<td>11</td>
</tr>
<tr>
<td>Twelve Months Extension</td>
<td>12</td>
</tr>
<tr>
<td>Case Transfers</td>
<td>20</td>
</tr>
</tbody>
</table>
A. Policy

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

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

When a Medicaid enrollee 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 enrollee must be informed of the findings of partial reviews and renewals and the action taken. The Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal. The Advanced Notice of Proposed Action is used to inform the enrollee 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 enrollee's Medicaid coverage or reducing the enrollee'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. Enrollee's Responsibility

The enrollee 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 an SSN, receipt of SSA benefits and the delivery date for a pregnant woman.

1. **Changes That Require Partial Review of Eligibility**

   When changes in an enrollee’s situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee’s circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the enrollee’s continued eligibility.

   A reported increase in income and/or resources can be acted on without requiring verification, unless 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 when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.

2. **Changes That Do Not Require Partial Review**

   When changes in an enrollee’s situation are reported or discovered, such as the enrollee’s SSN and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

   Example: The Medicaid enrollee who did not have an SSN, but applied for one when he applied for Medicaid, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee’s newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee’s verified SSN in MMIS and ADAPT.

3. **HIPP Requirements**

   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 and is eligible for coverage under an employer’s group health plan. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee’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 (NOT 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 (NOT 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 Aid Category (AC) in MMIS will automatically be changed to 092 or 094. No action is required when the child is enrolled as AC 092. If the child is enrolled as AC 094, 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 AC 094 effective the end of the month and reinstate coverage in AC 092 effective the first day of the following month. **Do not use change transactions to move a child to or from AC 094.**

3. SSI Medicaid Enrollee Becomes a Qualified Severely Impaired Individual (QSII) - 1619(b)

When an SSI Medicaid enrollee 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 via the State Online Query Internet (SOLQ-I) or the State Verification Exchange System (SVES) must be completed. To identify a 1619(b) individual, check the “Medicaid Test Indicator” field on the SOLQ-I or SVES screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the AC to the appropriate AC.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all Medicaid enrollees, 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.

1. 12-Month Renewal Period

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 enrollees due for renewal.
2. **Scope of Renewals**

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, a verified Social Security number or verified United States citizenship.

3. **Ex Parte Renewal**

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 the enrollee 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.

4. **Medicaid Renewal Forms**

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 (available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) and verifications necessary to determine ongoing eligibility before the coverage is cancelled.

The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) forms are acceptable when the individual is required to complete them for another program under which he is receiving benefits. These forms are available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

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 confidentially 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 enrollee 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.

The enrollee 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.

<table>
<thead>
<tr>
<th>2. Income Verification Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income verification no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of verifications of income in the case record. If a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source and a description of the information.</td>
</tr>
</tbody>
</table>

When the enrollee has reported that he has no income ($0 income), the enrollee must be given the opportunity to report income on a renewal form. Do not complete an ex parte renewal when the enrollee has reported $0 income.

<table>
<thead>
<tr>
<th>3. Renewal For SSI Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Coordination With Other Benefit Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>When an ongoing F&amp;C Medicaid enrollee 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Medicaid Renewal Form Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a Medicaid Renewal form is required, the form must be sent to the enrollee no later than the 11th month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the enrollee to sign and return or can be mailed to the enrollee 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.</td>
</tr>
</tbody>
</table>

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the enrollee 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.

<table>
<thead>
<tr>
<th>C. Special Requirements for Certain Covered Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Woman</td>
</tr>
<tr>
<td>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</td>
</tr>
</tbody>
</table>
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 Review Requirements

The Medicaid eligibility of women in the FPS covered group must be evaluated 12 months following the end of the pregnancy. This includes the month in which the pregnancy ended and the 60-day post-pregnancy period for pregnant women covered groups. Example: Pregnancy ended on July 13, 2006, the date the baby was born. The twelfth month from July 2006 (including July) is June 2007. The woman is not enrolled in FPS until October 1, 2006, because she received full coverage in AC 091 through September 30, 2006. MMIS calculates her maximum FPS eligibility period (24 months from pregnancy end date, including the month the pregnancy ended) and enters an end date of June 30, 2008. Her FPS eligibility must be redetermined before the June 2007 cutoff.

At the time of renewal, if the woman is 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 the full coverage begins. Reinstate full coverage beginning the first day of the following month.

If the woman is eligible only for FPS, she remains enrolled in FPS for the remainder of the maximum FPS eligibility period as long as her eligibility continues. Income and other changes reported after the twelfth month from the end of the pregnancy must be evaluated to determine if she remains eligible for FPS.

For example, if her income goes above the 133% FPL limit after the twelfth month from the pregnancy end date, she is no longer eligible for FPS regardless of the end date of the FPS coverage period in MMIS. If action is taken before cutoff of the FPS end month indicated in MMIS, her FPS coverage must be canceled in MMIS using the appropriate cancel reason code, and she must be sent advance notice of the cancellation.

3. Newborn Child Turns Age 1

An application for a child enrolled as a Newborn Child Under Age 1 must be filed before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- an application (see M0120.300)
- verification of citizenship and identity
- SSN or proof of application
- verification of income
- verification of resources for the MN child.

4. Child Under Age 19 (FAMIS Plus)

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 FAMIS Plus 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 reinstated in FAMIS and there is no break in coverage.

**Do not use change transactions to move a child between Medicaid and FAMIS.**

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

5. **FAMIS Plus**
   
   **Child Turns Age 19**
   
   When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.
   
   If 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 enrollee who is enrolled as a child under age 21 attains age 21, determine from the case information if the enrollee meets a definition for another covered group, such as blind, disabled, or pregnant woman.

7. **IV-E FC 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 Treatment Act (BCCPTA)**
   
   The BCCPTA Redetermination, form #032-03-653, is used to redetermine eligibility for the BCCPTA covered group. The renewal form is available on-line at: [http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi](http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi). The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

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

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

LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 (available at [http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi](http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi)) for the annual renewal. The DMAS-122 must be updated at least every 12 months even when there is no change in the patient pay.

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

M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION

M1520.401 NOTICE REQUIREMENTS

A. Policy

Following a determination that eligibility no longer exists or that the 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. If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The “Advance Notice of Proposed Action” must inform the recipient of the last day of Medicaid coverage.


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.

3. **Matches That Require Advance Notice**

   The following list indicates some of the computer match sources which require a ten (10) day advance notice.

<table>
<thead>
<tr>
<th>Match Source</th>
<th>Notification Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Revenue Service (IRS) unearned income files</td>
<td>10 days</td>
</tr>
<tr>
<td>Beneficiary and Earnings Data Exchange (Bendex)</td>
<td>10 days</td>
</tr>
<tr>
<td>State Data Exchange (SDX)</td>
<td>10 days</td>
</tr>
<tr>
<td>Enumeration Verification System (SSN)</td>
<td>10 days</td>
</tr>
<tr>
<td>Systematic Alien Verification For Entitlements (SAVE)</td>
<td>10 days</td>
</tr>
<tr>
<td>Department of Motor Vehicles (DMV)</td>
<td>10 days</td>
</tr>
<tr>
<td>Virginia Employment Commission (VEC)</td>
<td>10 days</td>
</tr>
<tr>
<td>Benefit Exchange Earnings Record (BEERS)</td>
<td>10 days</td>
</tr>
</tbody>
</table>

D. **Procedures**

1. **Action Appealed**

   Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer will notify the local agency whether to continue coverage during the appeal.

   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 is not continued when a request for appeal is filed on or after the effective date of the action.

   When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.
2. **Death of Recipient**

Adequate notice of cancellation must be sent to the estate of the recipient at the recipient's last known address when information is received that the recipient is deceased. The effective date of cancellation in the MMIS computer eligibility file is the date of death.

3. **End of Spenddown Period**

When eligibility automatically terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the "Notice of Action on Medicaid (NOA)" sent at the time the application is approved. Explanation of this limitation and information relative to reapplication is provided at the time of the eligibility determination and enrollment.

**M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION**

**A. Introduction**

1. **MMIS Computer Transaction**

A case must be canceled in the Medicaid computer prior to the date of the proposed action. The change to the MMIS recipient file must be made after cut-off in the month the proposed action is to become effective. For example, if the NOA specifies the intent to cancel on October 31, a change to the Medicaid computer is made prior to cut-off in October.

In the event the proposed action is not taken or an appeal is filed prior to the proposed date of action, the case must be immediately reopened.

2. **Reason "012" Cancellations**

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the NOA. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

*Cancel actions done by DMAS staff or the MMIS are reported in the Client Information Document (CID) report available on the intranet at: [https://securelocal.dss.virginia.gov/reports/benefits/vammis/index.cgi](https://securelocal.dss.virginia.gov/reports/benefits/vammis/index.cgi)*

**M1520.403 RECIPIENT REQUESTS CANCELLATION**

A recipient may request cancellation of his Medicaid coverage. The request must be written and documented in the record. When the recipient requests cancellation of Medicaid, the local department must send an NOA to the recipient no later than the effective date of cancellation. On the notice:

4. check the "other" block and list the reason as "recipient's request,"

5. instruct the recipient to discontinue using the card after the effective date of cancellation, and

6. instruct the recipient to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

Cancel Medicaid coverage in the MMIS using the cancel reason "004".
**M1520.500 EXTENSIONS OF MEDICAID COVERAGE**

**A. Policy**

Medicaid recipients may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to increased income from child and/or spousal support may be eligible for a 4-month extension.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a 12 months extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

NOTE: Children must first be evaluated for Medicaid eligibility in the MI Child Under Age 19 (FAMIS Plus) covered group and if eligible, enrolled using the appropriate MI Child Under Age 19 AC. If ineligible as MI, the child must be evaluated for the Medicaid extensions. If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the family must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage.

**B. Procedure**

The policy and procedures for the four-month extension are in section M1520.501 below.

The policy and procedures for the twelve-month extension are in section M1520.502 below.

**M1520.501 FOUR-MONTH EXTENSION**

**A. Policy**

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;

- The family lost eligibility solely or partly due to receipt of or Increased child or spousal support income; and

- All other Medicaid eligibility factors except income are met.

**B. Procedures**

1. **Received in Error**

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family unit who received Medicaid, erroneously during 3 or more of the 6 months proceeding the month of ineligibility does not qualify for the Medicaid extension.
2. **New Family Member**

A new member of the family unit is eligible for Medicaid under this provision if he/she was a member of the unit in the month the unit became ineligible for LIFC Medicaid. However, even if a baby was not born as of that month, a baby born to an eligible member of the unit during the 4-month extension is eligible under this provision because the baby meets the categorically needy non-money payment newborn child under age 1 covered group.

3. **Moves Out of State**

Eligibility does not continue for any member of the family unit who moves to another state.

4. **Coverage Period**

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of support income.

5. **Aid Category**

Cases eligible for this four-month extension are categorically needy non-money payment. A Medicaid-Only application and case are recorded statistically. The aid category (AC) for the recipients in the unit remains "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.

6. **Case Handling**

Those cases closed in a timely manner must be held in a suspense file until the fourth month after the LIFC Medicaid cancellation month. At that time, action must be taken to evaluate continuing Medicaid eligibility.

If all eligibility factors are met, the children in the case may continue eligible as MI or medically needy. Make the appropriate AC changes to the enrollee’s MMIS record.

The caretaker's Medicaid coverage must be canceled if he/she does not meet a Medicaid covered group. An appropriate "Advance Notice of Proposed Action", form 032-03-018 must be sent to the recipient if the caretaker or the case is no longer eligible for Medicaid.

**M1520.502 TWELVE-MONTHS EXTENSION**

**A. Policy**

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;

- The family lost eligibility solely or partly due to receipt of or increased income from earnings or expiration of $30 + one-third or $30 earned income exclusion; and

- All other Medicaid eligibility factors except income are met.

The family consists of those individuals living in the household whose needs and income were included in determining the LIFC Medicaid
eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.

The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in 3 of 6 Months
   The family received LIFC Medicaid in at least 3 of the 6 months immediately proceeding the month in which the family became ineligible for LIFC.

2. Cancel Reason
   LIFC Medicaid was canceled solely because of:
   - the caretaker/relative's new employment,
   - the caretaker/relative's increased hours of employment,
   - the caretaker/relative's increased wages of employment, or
   - expiration of any assistance unit member's $30 plus 1/3, or $30, earned income disregard.

3. Has A Child Living in Home
   The family continues to have at least one child under age 18, or under age 19 if in school, living in the home.

4. Complies With HIPP
   The family complies with the Health Insurance Premium Payment (HIPP) Program requirements. (See subchapter M0290).

5. No Fraud
   The family has not been determined to be ineligible for LIFC Medicaid because of fraud any time during the last six months in which the family received LIFC Medicaid.

C. Entitlement & Enrollment

Entitlement does not continue for any member of the unit who moves to another state.

*Enrollees* receiving this extension are categorically needy non-money payment, aid category (AC) "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.

1. Determining Extension Period
   Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC Medicaid because of excess income due to any unit member's expiration of the $30 plus 1/3 or $30 earned income disregard, or due to the increased earnings of the caretaker/relative. Extension for an additional 6-month period is possible if the reporting and financial requirements are met (below).
a. New/increased Earnings Not Reported Timely

When the new/increased earnings were not reported so that action to cancel LIFC Medicaid could be taken in a timely manner, the extension period begins the month following the month the assistance unit would have last received LIFC Medicaid if reported timely.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month period begins with May, the first month the family's LIFC Medicaid should not have been received. The screening period to determine if the family unit received LIFC Medicaid in at least 3 of the six months immediately preceding the month in which the unit became ineligible for LIFC Medicaid will be November to April.

b. Simultaneous Income Changes

In situations where an earned income case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings or loss of the disregards. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income or loss (expiration) of the disregards.

1) If the family would have been ineligible for one of these reasons, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the 12-month Medicaid extension.

2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings or expiration of the disregards, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The family is not eligible for the Medicaid extension.

2. Extension Ends

Entitlement to Medicaid under this extension period terminates at the end of the first month in which the family unit ceases to include a child under age 18 or under age 19 if in school, the family unit fails to comply with the Health Insurance Premium Payment (HIPP) Program requirements or the reporting requirements in D below, or at the end of the extension period.

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined prior to canceling the child(ren)'s Medicaid coverage. An “Advance Notice of Proposed Action” must be sent prior to canceling extended Medicaid coverage.

D. Notice and Reporting Requirements

1. LIFC Medicaid Cancellation Month

When LIFC Medicaid is canceled, the unit must be notified of its entitlement to extended Medicaid coverage for six months, and that
Medicaid coverage will terminate if the child(ren) in the family turns age 18, or turns age 19 if the child is in school.

The family unit must be instructed to retain verifications of all earnings received and the costs of child care during each month of the extension, and to send the "Medicaid Extension Earnings Report" and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period.

The names of the three months in the three-month period must be written out on the notice form and the report form whenever either form is sent to the family unit.

2. Third Month of Extension

In the third month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report", with the earnings and child care cost verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be sent automatically by the Medicaid computer if the correct follow-up code and effective date of the 12-month extension are entered in the base case information fields. If the code and effective date are not entered correctly or in a timely manner, the agency must manually send the notice.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period.

a. Notice Requirements

The Medicaid computer will send the advance notice and automatically cancel coverage at the end of the sixth month if the initial follow-up code and extension effective date were entered correctly, and the code is not updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the advance notice of Medicaid cancellation and must cancel the family's coverage in the computer after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

b. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category before the cut-off date of the sixth extension.
month. If not eligible, leave the child's enrollment (and the base case follow-up code and follow-up date fields) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the cut-off date of the sixth extension month, the computer will cancel coverage. The agency must then reopen the child(ren)'s Medicaid if the child(ren) is determined eligible and must notify the recipient of the reopened coverage.

c. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. The follow-up code must be changed in the Medicaid computer base case information when the report is received in order for Medicaid to continue. No action is taken on the first three-month period's earnings and the extension continues.

4. Sixth Month of Extension

In the sixth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month) with the earnings and child care cost verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

The Medicaid computer will automatically send this notice if the follow-up code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

If the second three-month period's report and verifications are not received by the 21st of the seventh month, the family's Medicaid coverage must be canceled after an Advance Notice of Proposed Action is sent. The Medicaid computer will send the advance notice and automatically cancel coverage if the report is not received on time and the code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are, illness or injury of family member(s) who is capable of obtaining and sending the material; agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category before the cut-off date of the eighth extension.
If not eligible, leave the child's enrollment (and the base case follow-up code and follow-up date fields) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the cut-off date of the eighth extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child is found eligible.

**b. Cancellation Effective Date**

Cancellation is effective the last of the eighth month of extension.

**c. Report Received Timely**

If the second three-month period's report is received by the 21st of the seventh month, change the base case follow-up code in the Medicaid computer immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

1) no child under age 18, or under age 19 if in school, lives with the family;

2) the family disenrolls from a group health plan that DMAS has determined cost-effective or fails to pay the premium to maintain the group health plan;

3) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to the caretaker/relative's involuntary lay-off, the business closed, etc., the caretaker/relative's illness or injury, or other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work); or

4) the family unit's average gross monthly earned income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% poverty income limit appropriate to the family unit size.

See subchapter M0710, Appendix 7 for the 185% poverty income limits.

**d. Calculate Family's Gross Earned Income**

1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-month period. “Gross” earned income is total earned income before any deductions or disregards. All earned income must be counted, including students’ earned income, JTPA earned income, children’s earned income, etc. No disregards are allowed.

2) Child care costs that are “necessary for the caretaker/relative’s employment” are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.
3) To calculate average gross monthly income:

- add each month’s cost of child care necessary for the caretaker/relative’s employment; the result is the three-month’s cost of child care necessary for the caretaker/relative’s employment.

- add the family unit’s total gross earned income received in each of the 3 months; the result is the family’s total gross earned income.

- subtract the three-months’ cost of child care necessary for the caretaker/relative’s employment from the family’s total gross earned income.

- divide the remainder by 3; the result is the average monthly earned income.

- compare the average monthly earned income to the monthly 185% poverty limit for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member’s eligibility for Medicaid in another covered group must be determined before canceling coverage.

Contact the recipient and request current verification of the family’s total income, including earned and unearned income. If eligible, change the enrollment to the appropriate aid category before cut-off in the eighth extension month.

2) If the family is ineligible because of excess income, cancel Medicaid coverage. If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS, and transfer the case to the FAMIS Central Processing Unit (CPU).

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

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for the extension, no action is required until the ninth month of extension, except to be sure that the follow-up code was updated in the computer when the income report was received.

6. Ninth Month of Extension

In the ninth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report” with earnings and child care cost verifications attached, for the previous three-month period (seventh through
ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

The Medicaid computer will automatically send this notice if the correct code is in the base case information on the computer. If it is not, the local agency must manually send this notice.

7. Tenth Month of Extension

If the third three-month period's report and verifications are not received by the 21st of the tenth month, the family's Medicaid coverage must be canceled after an advance notice is sent. The Medicaid computer will automatically cancel coverage and send the advance notice if the report is not received on time and the follow-up code is not changed. Medicaid coverage must be canceled unless the family establishes good cause for failure to report timely (see 5. above for good cause).

a. Determine Child(ren)'s Eligibility

If the report is not received on time, the child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income. If eligible, change the child(ren)'s enrollment to the appropriate aid category before the cut-off date of the eleventh extension month. If not eligible, leave the child's enrollment (and the base case follow-up code and follow-up date fields) as it is and the computer will cancel the child(ren)'s coverage.

If the child(ren)'s eligibility is not reviewed by the cut-off date of the eleventh extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child(ren) is found eligible.

b. Cancellation Effective Date

Cancellation is effective the last day of the eleventh month of extension.

c. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, change the base case follow-up code in the Medicaid computer immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in 5.c. above applies. Calculate the family’s income using the procedures in 5.d. above.

d. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to extended Medicaid coverage, review their eligibility for Medicaid in another category or for FAMIS or FAMIS MOMS. If not eligible, cancel Medicaid after sending the Advance Notice of Proposed Action. Cancellation is effective the last day of the eleventh month of extension.
If the family is ineligible because of excess income, cancel Medicaid coverage. **Send the Advance Notice of Proposed Action.**

*If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS and transfer the case to the FAMIS Central Processing Unit (CPU).*

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

e. **Family Remains Entitled To Extended Medicaid**

If the family remains entitled to extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

**8. Twelfth Month of Extension**

Before Medicaid cut-off in the twelfth month, complete the family's redetermination. The Medicaid computer will automatically cancel coverage and send the advance notice after cut-off of the twelfth month, if the follow-up code was updated correctly. Therefore, for any of the family members that remain eligible for Medicaid or FAMIS-FAMIS MOMS, the AC and the follow-up code must be changed before cut-off of the twelfth month.

*If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS and transfer the case to the FAMIS Central Processing Unit (CPU).*

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

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

**M1520.600 CASE TRANSFERS**

**A. Introduction**

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

**B. Nursing Facility and Assisted Living Facility (ALF)**

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

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

The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from DMHMRSAS facilities are in subchapter M1550. F&C cases are not transferred.

D. DMAS FAMIS Plus Unit FIPS 976

The Medicaid cases approved by the DMAS FAMIS Plus 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 FAMIS Plus Unit. Cases from the DMAS FAMIS Plus 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 must make certain the case is current and complete before transferring the case. If the annual renewal has been completed within the past 11 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed.

If the annual renewal is due, it must be completed if an ex parte renewal can be done; however, if an ex parte renewal cannot be done, do not delay transferring the case. Send the Medicaid Renewal form to the recipient with instructions to return it to the local agency in the new locality and note the pending renewal on the Case Record Transfer Form.

If the annual renewal or 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 renewal or 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 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.
# DMHMRSAS Facilities

## Medicaid Technicians

<table>
<thead>
<tr>
<th>NAME</th>
<th>LOCATION</th>
<th>WORK TELEPHONE</th>
<th>CASELOAD</th>
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<tbody>
<tr>
<td></td>
<td>Mail to: P. O. Box 1098 Lynchburg, VA 24505</td>
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</tr>
<tr>
<td></td>
<td>Mail to: P. O. Box 1098 Lynchburg, VA 24505</td>
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</tr>
<tr>
<td>Janet Benton</td>
<td>Central State Hospital Medicaid Office P. O. Box 4030 Petersburg, VA 23803</td>
<td>804-524-7582</td>
<td>SSVTC-caseload-all Hiram-Davis-caseload-all PGH-caseload-A-G</td>
</tr>
<tr>
<td>Debra J. Quesenberry</td>
<td>Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070</td>
<td>540-375-4350 or 800-828-5158</td>
<td>Catawba-caseload-all NVTC-caseload-all</td>
</tr>
<tr>
<td>Frances Jones</td>
<td>Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354</td>
<td>276-783-0841</td>
<td>SWVTC-caseload-all ESH-caseload-A-J</td>
</tr>
<tr>
<td>Terri Neel-Kinder</td>
<td>Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354</td>
<td>276-783-0842</td>
<td>SEVTC-caseload-all ESH-caseload-K-Z SWVMHI-caseload-all</td>
</tr>
</tbody>
</table>

**NOTE:** Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DMHMRSAS Facilities:
- CVTC – Central Virginia Training Center
- ESH – Eastern State Hospital
- NVTC – Northern Virginia Training Center
- PGH – Piedmont Geriatric Hospital
- SEVTC – Southeastern Virginia Training Center
- SSVTC – Southside Virginia Training Center
- SWVMHI – Southwestern Virginia Mental Health Institute
- SWVTC – Southwestern Virginia Training Center
- WSH – Western State Hospital
# TABLE OF CONTENTS

M17  MEDICAID FRAUD AND RECOVERY

M1700.000  MEDICAID FRAUD AND RECOVERY

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Fraud</td>
<td>1</td>
</tr>
<tr>
<td>Non-Fraud Recovery</td>
<td>3</td>
</tr>
<tr>
<td>Responsibility of the Local DSS</td>
<td>5</td>
</tr>
</tbody>
</table>

## Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient Fraud/Non-Fraud Referral</td>
<td>1</td>
</tr>
<tr>
<td>Medicaid Claims Request</td>
<td>1</td>
</tr>
</tbody>
</table>
M1700 MEDICAID FRAUD AND RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency

The Department of Medical Assistance Services (DMAS) is responsible for the investigation and referral of fraudulent and erroneous payments made by the Medicaid Program. DMAS can recover any payment erroneously made for services received by a Medicaid recipient or former Medicaid recipient. Recovery can be made from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempted from collection efforts by State or Federal law or regulation.

A. Utilization Review

Recipients' utilization of all covered services is monitored regularly by DMAS. Whenever the utilization of services is unusually high, the claims for services are reviewed for medical necessity. If some services are considered not medically necessary, the recipient will be contacted by the DMAS Recipient Monitoring Unit.

DMAS also reviews hospital claims prior to payment to determine if the 21-day limit is exceeded or if the length of stay regulations are met. All provider claims are reviewed and audited after payment.

M1700.200 FRAUD

A. Definitions

Fraud is defined as follows:

"Whoever obtains, or attempts to obtain, or aids and abets a person in obtaining, by means of a willful false statement or representation, or by impersonation, or other fraudulent device, assistance or benefits from other programs designated under rules and regulations of the State Board of Social Services or State Board of Health to which he is not entitled, or fails to comply with the provisions of .63.1-112, shall be deemed guilty of larceny...." (Code of Virginia, .63.1-124).

"If at any time during the continuance of assistance there shall occur any change, including but not limited to, the possession of any property or the receipt of regular income by the recipient, in the circumstances upon which current eligibility or amount of assistance were determined, which would materially affect such determination, it shall be the duty of such recipient immediately to notify the local department of such change, and thereupon the local board may either cancel the assistance, or alter the amount thereof." (Code of Virginia, .63.1-112).

B. DMAS Responsibilities

1. Recipient Fraud

DMAS has sole responsibility for handling cases of suspected fraud by Medicaid recipients when eligibility for a public assistance payment is not involved (Medicaid only cases). Medicaid cases involving suspected fraud must be
referred to DMAS, Recipient Audit Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the format for the Recipient Fraud/Non-Fraud Referral in Appendix 1 to this chapter. The following information must be provided:

- recipient’s name and Medicaid number;
- recipient’s social security number;
- reasons for and exact dates of ineligibility for Medicaid;
- applicable Medicaid applications or review forms for the referral/eligibility period;
- address and telephone number of any attorney-in-fact, authorized representative, or other individual who assisted in the application process;
- relevant covered group, income, resource, and/or asset transfer documentation;
- any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and
- information obtained from the agency’s fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.

This format has been specifically designed to be used in conjunction with the DMAS Fraud Abuse Information Reporting System and the format must not be altered.

The current threshold for Administrative Recoveries of Medicaid fraud is $300.00. It is not feasible for DMAS to pursue cases with losses less than this threshold. If there is a question regarding the amount of the loss of Medicaid funds, the local agency must submit a Medicaid Claims Request (see Appendix 2 to this chapter) to DMAS and obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e. expedited trial dates. Once the information is received and it is determined that the loss exceeds the threshold for recovery, the local agency must send the Recipient Fraud/Non-Fraud Referral to DMAS.

There is no threshold for any case with criminal intent to defraud Medicaid.

2. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients must be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General. A copy of the information sent to the Medicaid Fraud Control Unit in the Office of the Attorney General must be sent to the Provider Review Unit, Department of Medical Assistance Services.
3. Suspected Fraud Involving Recipients of Public Assistance

a. Temporary Assistance for Needy Families (TANF) and Auxiliary Grant (AG) Cases

Cases of suspected fraud involving ineligibility for a TANF or AG payment are the responsibility of the local department of social services. The local agency determines the period of ineligibility for Medicaid, and the DMAS Recipient Audit Unit provides the amount of Medicaid payments made. The amount of misspent Medicaid funds must be included in the TANF or AG fraud cases, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases must be communicated to the Recipient Audit Unit, DMAS, no later than 5 business days after disposition for inclusion in federal reporting.

b. Food Stamps, General Relief (GR), Fuel, etc.

For suspected fraud involving Food Stamps, GR, Fuel, or other such assistance which does not directly relate to the provision of Medicaid, the local agency must notify the Recipient Audit Unit of the agency's action on the other assistance case so that Medicaid can take concurrent action if necessary.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

When an individual has been convicted of Medicaid fraud by a court, that individual will be ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage must be taken in the month of conviction or in the month the agency learns of the conviction using cancel reason 14.

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

In a TANF or F&C Medicaid case, only the parent/caretaker will be ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment for the caretaker may not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.

3. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.
M1700.300 NON-FRAUD RECOVERY

A. Definition

The Virginia State Plan for Medicaid defines Non-Fraud Recovery as: "Investigation by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud." These cases are referred to DMAS when there is reason to suspect that an overpayment has occurred. (42 CFR§431).

B. Recovery of Misspent Funds

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. The situations in which recovery of expenditures are possible include, but are not limited to:

- when eligibility errors are due to recipient misunderstanding,
- when agency errors are made, or
- when medical services are received during the appeal process and the agency's cancellation action is upheld.

C. Recovery of Funds Correctly Paid

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients

1. Deceased Recipient's Estate

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee’s estate when the recipient was age 55 or over. The recovery can include any Medicaid payments made on his/her behalf. This claim can be waived if there are surviving dependents. (42 CFR 433.36; Va. Code §32.1-326.1 and 32.1-327).

2. Uncompensated Property Transfers

DMAS may seek recovery when a Medicaid enrollee transferred property with an uncompensated value of more than $25,000. The transferees (recipients of the transfer) are liable to reimburse Medicaid for expenditures up to the uncompensated value of the property or resource. The property transfer must have occurred within 30 months of the recipient (transferor) becoming eligible for or receiving Medicaid. (Va. Code §20-88.02).

3. Local DSS Referral

When an agency discovers a Medicaid case involving property transfers, a Notice of Medicaid Fraud/Non-fraud Overissuance (form # DMAS 751R; see M1700, Appendix 1) must be completed and sent to:

Supervisor
Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Estate recoveries must be referred to:

Estate Recovery Unit, Fiscal Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Cases involving insurance related recoveries must be referred to:

Third-Party Liability Section
Fiscal Division, Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

M1700.400 RESPONSIBILITY OF THE LOCAL DSS

A. Introduction DMAS shares an interagency agreement with the Virginia Department of Social Services (VDSS) which lists specific responsibilities. Local departments of social services are responsible for referring and reporting the following situations to DMAS:

- Investigations "by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud"; and

- Instances where there is evidence that fraud may exist.

B. VDSS Responsibilities To assist in the prevention of receipt of non-entitled services by enrollees, VDSS must use the Notice of Medicaid Fraud/Non-fraud Overissuance (form # DMAS 751R) contained in M1700, Appendix 1 to:

- Notify DMAS of every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement;

- Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014);

- Notify DMAS of all instances in which a Medicaid recipient is a beneficiary of a discretionary trust and the trustee refuses to make the assets available for the medical expenses of the recipient, or when a Medicaid recipient has been found to be ineligible for Medicaid benefits as a result of a transfer of assets; and

- Include Medicaid expenditures in the computation of misspent funds, where a withholding or a deliberate misrepresentation of a pertinent fact
has taken place and where a local social service agency will exercise jurisdiction in regard to prosecution of the case.

B. Statute of Limitations

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud should be flagged to ensure that the information is not purged. Cases cannot be properly investigated without specific documents, i.e. signed applications, bank statements, burial or insurance information. DMAS will notify the agency of the results of the fraud investigation.
NOTICE OF RECIPIENT FRAUD/NON-FRAUD OVERISSUANCE

DATE: _______/_______/_______

TO: RECIPIENT AUDIT UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA  23219

TYPE OF REFERRAL
Agency Error____
LTC Underpayment____
Drug Related____
Other____

Case Name: ________________________________

Case Address: ________________________________

__________________________________________

Case Name Social Security #:_____________________________

Medicaid ID#:    -    -    -    -    -

(Check appropriate box below)

☐ Ineligible for Medicaid Dates: ___________________________
(Explanation of Ineligibility in summary section)

☐ Underpayment for Medicaid LTC (List months, amounts and explanation in summary section)

Summary:

_____________________________________________________

_____________________________________________________

_____________________________________________________

Eligibility Worker/Medicaid Technician Telephone Number

__________________________    (____)___________________

__________________________

Address City/County Code (FIPS)

Please attach all documentation listed in M1700.200 B.1 to the referral form. You will be contacted by the Recipient Audit Unit if follow-up is necessary.
RECIPIENT FRAUD/NON-FRAUD REFERRAL FORM INSTRUCTIONS

FORM NUMBER - DMAS 751R (7/00)

PURPOSE

To report to the DMAS Recipient Audit Unit any instance of allegations of criminal or civil acts committed against the Medicaid and/or SLH. Such acts include, but are not limited to: 1) those involving the eligibility of persons receiving Medicaid under ABD, Aid to Refugees, TANF-who do not qualify for a money grant; 2) allegations of illegal use of a Medicaid card or receipt of benefits under the Program by means of an illegal act; 3) allegations of crimes committed against the Program by any person other than a provider of services; 4) allegations of uncompensated transfer of property by recipients; 5) refusal of the trustee of a discretionary trust to pay all or part of the beneficiary’s medical expenses; *6) any agency error, as well as Long Term Care underpayments.

*Recipient enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period, information known to the agency that would render ineligibility, etc.

USE OF FORM – Completed for all cases that are being referred to the Recipient Audit Unit for possible fraud, ineligibility or incorrect patient pay.

NUMBER AND DISTRIBUTION OF COPIES – Prepare original; make a copy for the agency record before sending to the Recipient Audit Unit at DMAS.

INSTRUCTIONS FOR PREPARATION OF FORM – The form should contain the recipient(s) name, current mailing address (no P.O. Box should be used), social security number for the case name and or responsible party, each individual recipient(s) number, period of ineligibility or period in which the underpayment occurred must be stated, summary or reason for the ineligibility of underpayment. *Attach all documentation listed in M1700.200 B.1 to the referral form.* If the referral relates to an underpayment, then the underpayment for collection must be stated for each month.

All Estate Recoveries and Third Party Liability referrals should be forwarded to the addresses specified in M1700.300.

The referring entity will be contacted should DMAS need additional case information or copies.
Commonwealth of Virginia
Department of Medical Assistance Services
Medicaid Claims Request

Date: ______________________

Agency: ____________________________
Worker’s Name: ______________________
Phone No: ____________________________

Recipient Audit Unit Supervisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Supervisor:

I am conducting an investigation of the person(s) listed below for the time period indicated. Please forward proof of claims paid by Medicaid during the investigative period.

I will keep you informed of additional progress and of the outcome of this investigation.

Case Name: ______________________ Base ID#: ____________________________

(a) _______________________________ Recipient ID#: _______________________
Period of suspected fraud/overpayment: ____________________________

(b) _______________________________ Recipient ID#: _______________________
Period of suspected fraud/overpayment: ____________________________

(c) _______________________________ Recipient ID#: _______________________
Period of suspected fraud/overpayment: ____________________________

(d) _______________________________ Recipient ID#: _______________________
Period of suspected fraud/overpayment: ____________________________

Sincerely,

Custodian Certificate/Claims needed? Y/N
Expected Date to the CA: __________________________
Expected Court Date: __________________________

DMAS 750R (7/00)
CLAIMS REQUEST FORM INSTRUCTIONS

FORM NUMBER - DMAS 750R (7/00)

PURPOSE

This form serves as a multi-purpose form: It can be used to receive certified claims from DMAS reporting the total expended amount of Medicaid services for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notorized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. It can also be used if the agency would like to know if the claims exceed the Recipient Audit Unit amount of $300.00 for Medicaid-Only referrals. This is helpful in determining whether or not the case should be referred to the Recipient Audit Unit for investigation.

Note: Providers have up to one year to bill for services, therefore the amount of claims may not be accurate or complete at the time of prosecution or inquiry. It is suggested that the Commonwealth’s Attorney be advised of this information, should additional claims develop at a later time and additional restitution be requested by DMAS.

USE OF FORM – Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). Also, request for an estimate of claims when determining whether or not the Medicaid-Only case meets the RAU threshold requirements.

NUMBER AND DISTRIBUTION OF COPIES – Prepare original; make a copy for the agency record before sending to the Recipient Audit Unit at DMAS.

INSTRUCTIONS FOR PREPARATION OF FORM – The form should contain the case name, the base case ID number, each recipient ID number and the period of suspected fraud/overpayment for each recipient. Each recipient should be listed separately as shown on the form by the letters (a) through (d). Should there be additional recipients on the same base case ID, a second page should be attached.

The requestor must complete the three questions in the lower left corner of the form in order for DMAS to determine the priority of the request.

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case.
# TABLE OF CONTENTS

M21 – FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMIS General Information</td>
<td>1</td>
</tr>
<tr>
<td>Nonfinancial Eligibility Requirements</td>
<td>2</td>
</tr>
<tr>
<td>Health Insurance Coverage</td>
<td>4</td>
</tr>
<tr>
<td>No Child Support Requirements</td>
<td>7</td>
</tr>
<tr>
<td>Financial Eligibility</td>
<td>7</td>
</tr>
<tr>
<td>Application and Case Procedures</td>
<td>8</td>
</tr>
<tr>
<td>Review of Adverse Actions</td>
<td>15</td>
</tr>
</tbody>
</table>

## APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMIS Income Limits</td>
<td>1</td>
</tr>
<tr>
<td>Virginia State Agency List</td>
<td>1</td>
</tr>
<tr>
<td>FAMIS Alien Eligibility Chart</td>
<td>1</td>
</tr>
</tbody>
</table>
M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children’s Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to uninsured low-income children.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State’s Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child’s application month if all eligibility requirements are met in that month, but no earlier than the date of the child’s birth.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child’s date of birth if the child would have met all eligibility criteria during that time.

Case management and ongoing case maintenance, and selection for managed care, are handled by the FAMIS CPU.

B. Legal Base

The 1998 Acts of Assembly, Chapter 464, authorized Virginia’s Children’s Health Insurance Program by creating the Children’s Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for FAMIS Plus (children’s Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is not eligible for FAMIS Plus due to excess income;
- he is under age 19 and a resident of Virginia;
• he is uninsured;

• he is not a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member’s employment with a State agency (see Appendix 2 to this chapter);

• he is not a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;

• he is not an inmate of a public institution;

• he is not an inpatient in an institution for mental diseases;

• he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and

• he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

• citizenship and alienage requirements, with the exceptions noted in M2120.100 C.1. below;

• Virginia residency requirements;

• institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

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

1. Alienage Requirements

Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements without regard to time limitations:
b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements after five years of residence in the United States:

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

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

Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

2. SSN

A Social Security number (SSN) or proof of application for an SSN (M0240) is not a requirement for FAMIS.

3. Assignment of Rights

Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

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 for at least one day during the month. No verification is required.

A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.
2. **Uninsured Child**
The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

3. **State Employee Prohibition**
A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member’s employment with a State agency.

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

**M2120.200 HEALTH INSURANCE COVERAGE**

A. **Introduction**
The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, or the child is pregnant.

B. **Definitions**

1. **Creditable Coverage**
   For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:
   
   • church plans and governmental plans;
   • health insurance coverage, either group or individual insurance;
   • military-sponsored health care;
   • a state health benefits risk pool;
   • the federal Employees Health Benefits Plan;
   • a public health plan; and
   • any other health benefit plan under section 5(e) of the Peace Corps Act.

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

2. **Family Member**
   When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, or whether the discontinuance of health insurance affects the child’s eligibility, family member means:
   
   • parent(s) with whom the child is living, and
   • a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

3. **Health Benefit Plan**
   “Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
   
   • “any accident and health insurance policy or certificate,
   • health services plan contract,
   • health maintenance organization subscriber contract,
   • plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.


Health benefit plan does not mean:

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

4. **Insured**

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

5. **Uninsured**

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

C. **Policy**

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

   - have creditable health insurance coverage;

   - have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.);

   - be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 2 to this chapter], or

   - without good cause (see item E. below), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

D. **Health Insurance Coverage Discontinued**

   If the child’s insurance coverage was discontinued by a parent or other individual who does NOT live with the child, the discontinuance of the insurance does NOT affect the child’s eligibility for FAMIS.

   A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated by a family member, as defined in M2120.200 B.3, above, without good cause within four months prior to the month for which eligibility is being established, unless the child was pregnant at the time of application.
Example: A child’s health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within four months of November. He may be eligible in April because his insurance was terminated more than four months prior to April.

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

E. Good Cause for Dropping Health Insurance

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

1. **Employment Stopped**
   - The family member who carried insurance changed jobs or stopped employment, and no other family member’s employer contributes to the cost of family health insurance coverage. Verification is not required.

2. **Employer Stopped Contributing**
   - The employer stopped contributing to the cost of family coverage and no other family member’s employer contributes to the cost of family health insurance coverage. Verification is not required.

3. **Insurance Company Discontinued Insurance**
   - 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.

4. **Discontinued By Family Member**
   - 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.

5. **Discontinued By Other Contributor**
   - 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.

6. **Discontinued Because Cost Exceeds 10% of Income**
   - Insurance on the child is discontinued because the cost of the health insurance premiums for all family members 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 health insurance premiums for all family members 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 child(ren)’s insurance was discontinued.

a. Use the applicant’s month-prior-to-application gross income verification.

b. Calculate 10% of the family’s gross monthly income.

c. Compare to total amount of monthly premiums.

d. If monthly premium is less than or equal to 10% of current gross monthly income:

1) 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.

2) Calculate 10% of the family’s gross monthly income (in the month in which the insurance was discontinued).

3) Compare to total amount of monthly premiums.

i. If monthly premiums are 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.

ii. If monthly premiums are more than 10% of this 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 FAMIS Plus (see chapter M07). There are no income disregards and no budget units in FAMIS.

5. Spenddown

Spenddown 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 Health Insurance for Children and Pregnant Women application is the application form for FAMIS. The Application for Benefits or the ADAPT Statement of Facts are also acceptable application/renewal forms for FAMIS. These forms are available on the intranet at:

http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi

The parent, legal guardian, authorized representative age 18 or older, an adult relative age 18 or older with whom the child lives, or the child if age 18, must sign the application. The adult relative must be related by blood or marriage. Accept declaration of relationship; documentation of the relationship is not required. The child’s parent or legal guardian may designate in writing an authorized representative age 18 or older to complete and sign the application. The date of the application is the date the application is received at the local DSS, including DSS outstationed sites, or at the FAMIS CPU.

Applications can be mailed to the local DSS or the CPU. A face-to-face interview is not required.

B. Eligibility Determination

When an application is received and the child is not eligible for FAMIS Plus due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met. Income must be verified. The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was
Children determined eligible for FAMIS are enrolled for benefits in the Medicaid Management Information System (MMIS) effective the first day of the child’s application month if all eligibility requirements are met in that month, but no earlier than the date of the child’s birth.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

a. Retroactive coverage must be requested on the application form or in a later contact.

b. The child’s date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child), but no earlier than June 1, 2006.

c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

The aid categories (ACs) for FAMIS are:

<table>
<thead>
<tr>
<th>AC</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>006</td>
<td>child under age 6 with income ≥ 150% FPL and &lt; 200% FPL</td>
</tr>
<tr>
<td>007</td>
<td>child 6 – 19 with income ≥ 150% FPL and &lt; 200% FPL</td>
</tr>
<tr>
<td>008</td>
<td>child under age 6 with income ≥ 133% FPL and ≤ 150% FPL</td>
</tr>
<tr>
<td>009</td>
<td>child 6 – 19 with income ≥ 133% FPL and ≤ 150% FPL</td>
</tr>
</tbody>
</table>

Because FAMIS Plus and FAMIS are separate programs, FAMIS Plus eligible individuals and FAMIS eligible children cannot share the same case number in the MMIS. When a child is determined eligible for FAMIS and the child has family members enrolled in FAMIS Plus in the MMIS, the FAMIS child must be given a new case number when enrolled in the MMIS. Only children eligible for the same program can share the same base case number in the MMIS.
After the child is enrolled in the MMIS, the local DSS worker must change the MMIS worker number to V0000 to transfer the case to the FAMIS CPU.

The local DSS worker must not change the FIPS code or make any other change to the case after the case has been transferred to FAMIS in the MMIS.

D. Notification Requirements

The local DSS worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both FAMIS Plus and FAMIS.

If the child is eligible for FAMIS, the notice must inform the family that the case has been transferred to FAMIS and that further information on the program will come from FAMIS.

If the child is ineligible for both FAMIS Plus and FAMIS, the family must be sent a notice that the child is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation. Along with the notice, send the Application for Benefits to the family and advise them that if the signed application is returned within 10 calendar days, the original application date will be honored.

E. FAMIS Case Transfer Procedures

Individuals approved for FAMIS are enrolled in MMIS by the LDSS and then transferred to the FAMIS CPU by changing the worker number to “V0000.” If a family has at least one child who is FAMIS Plus or Medicaid-eligible and at least one child who is FAMIS-eligible, the Medicaid case remains at the LDSS and a separate FAMIS case is created in MMIS via the ADAPT “Medicaid Authorization” (AEAUTM) screen. When granted, ADAPT changes the worker number to V0000 on the FAMIS case in the MMIS.

The worker sends the FAMIS-related case material, including copies of the income verification, to the FAMIS CPU via the courier by the end of the business day following the eligibility determination so the managed care assignment can be initiated. The LDSS retains the original application, verifications and the notice, and has responsibility for ongoing case maintenance of the FAMIS Plus case.

1. Case Material Sent to CPU

The documentation necessary for a case transfer to the FAMIS CPU has been modified. To allow the FAMIS CPU to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the following documents:

a. The ADAPT Statement of Facts (SOF). The SOF does not need to be signed. If the case is not in ADAPT, send a copy of the most recent application form. If transferring a case after a renewal, send a copy of the most recent completed application form plus the most recent renewal form. The CPU cannot accept the Medicaid Renewal Form by itself because it does not contain all the demographic information necessary to enter the family into the CPU’s computer system.
b. For an ADAPT case, print copies of the ADAPT income detail screens from the Application Entry Income Eligibility submenu for each family member who has income. The CPU needs to know the source of the income, the employer’s name (if the income is earned), the amount of income received each time it is paid to the individual, and the frequency of the income. This information is on the income detail screen; it is not on any wrap-up screen.

If the case is not in ADAPT, include a copy of a written eligibility evaluation form that has the income source details (source name, employer name, date(s) the income was received, frequency, and the eligibility calculations).

b. Copies of the appropriate ADAPT Medicaid Wrap-up screen(s):

- “MC F&C FAMIS Family Unit Income Test” (AEXXIU) for FAMIS children.
- “MC MI & FAMIS PG Family Unit Income Test” (AEMCFU) screen, and “MC MI & FAMIS PG Budget Unit Income Test” (AEMCAU) screen if budget units were formed, for FAMIS MOMS-enrolled pregnant women.

If the case is not in ADAPT, include a copy of a written eligibility evaluation form in place of these ADAPT wrap-up screen prints.

c. Income verifications if any individual in the assistance unit has income.

d. A copy of the ADAPT Notice of Action (NOA), or a copy of the written NOA, that was sent to the applicant about the FAMIS or FAMIS MOMS eligibility.

e. A completed Case Record Transfer sheet.

Additional case information that is not used to determine FAMIS eligibility should not be sent to the CPU.

2. Sending Case to the CPU

When transferring a case, confidentiality must be ensured by placing the case documents in a sealed interdepartmental envelope that is addressed to the FAMIS CPU (FIPS 976) and sent via the courier no later than the business day following the FAMIS eligibility determination. This ensures timely receipt of the case by the CPU so that the managed care assignment can be initiated, and the eligible individuals can be sent a FAMIS eligibility confirmation “packet” of information about their managed care assignment and the amount of their co-pay for covered services.

If the case is mailed via the United States Postal Service’s certified mail, the envelope must contain the full mailing address of the FAMIS CPU:

FAMIS CPU
P.O. Box 1820
Richmond, VA 23218-1820
F. Transitions Between 
FAMIS Plus And 
FAMIS (Changes 
and Renewals) 

When excess income for FAMIS Plus causes the child’s eligibility to change from FAMIS Plus to FAMIS, the new income must be verified. Copies of the income verifications must be sent to the FAMIS CPU with the transferred case material.

1. Actions 
Required 

Transitions between FAMIS Plus and FAMIS require cancellation of the current coverage and reinstatement in the new coverage, and may require additional coordination between the LDSS and the FAMIS CPU. Certain MMIS transactions can only be done by the FAMIS CPU, the DMAS FAMIS Plus Unit or the LDSS. Only the FAMIS CPU can cancel FAMIS or FAMIS MOMS coverage when the case is in worker number V0000. Only the LDSS can cancel FAMIS Plus coverage for cases that are active or connected to active cases in ADAPT or MMIS. The DMAS FAMIS Plus Unit can add or reinstate FAMIS Plus coverage only on cases processed by the DMAS FAMIS Plus Unit. The LDSS is responsible for reinstating FAMIS Plus coverage on cases processed by the LDSS and may cancel FAMIS Plus coverage and reinstate FAMIS coverage.

2. Case Transfer 
When Program 
Changes 

When eligibility transitions between FAMIS Plus and FAMIS, there must be communication between the FAMIS CPU, the LDSS, and the applicant. The Case Record Transfer Form (#032-32-227) must be completed by the sender and attached to the case record. The sender must also notify the applicant of the case transfer. The receiver must confirm receipt of the case by completing the Case Record Transfer Form and returning it to the sender. The receiving agency is not required to complete a FAMIS Plus redetermination until a change is reported or at the time of the next annual redetermination.

So that the FAMIS CPU will be able to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the documents listed in section M2140.100 E., above.

G. Communicating 
Changes to the CPU 

The Children’s Health Insurance Communication Form (#032-03-630) is used by the LDSS to communicate changes to the FAMIS CPU on FAMIS and FAMIS MOMS cases. This form can be downloaded from the DSS intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

The form must include the case name, the MMIS name and enrollee identification number, the reason for the communication, and all other relevant information. The FAMIS CPU must receive the Communication Form by the 10th calendar day of the month in order for the FAMIS/FAMIS MOMS cancellation to be effective by the end of the current month. If the form is received after the 10th calendar day of the month, the cancellation will be effective the last day of the following month.

H. FAMIS CPU 
Responsibilities and 
Procedures 

Applications, Redetermination applications (sent to a FAMIS recipient when a change is reported to the CPU), and renewals are faxed or mailed to the FAMIS CPU by applicants or recipients. Within three days of receipt, the CPU staff logs the application, redetermination or renewal into the FAMIS
eligibility system. There are no drop-offs and no face-to-face contact with applicants or recipients at the CPU. All applications are scanned and linked for electronic data recovery.

If an application is complete when it arrives at the FAMIS CPU, it takes approximately 12 business days or less to process the case. In order for an application to be complete, it must be signed and must include all required verifications. If the application is not complete when it is received, a “deficiency letter” is sent and the family is given 30 days to respond. In such cases, it can take more than 30 days to process the case. If the required verification is not received by the 30th day, the application is denied for failure to provide information, and the family is notified of the action.

When an application is approved for FAMIS or FAMIS MOMS, the FAMIS CPU initiates the managed care assignment and provides ongoing case maintenance. When an application is not FAMIS Plus-likely and is not eligible for FAMIS or FAMIS MOMS, the CPU sends the denial or cancellation notice to the applicant. When an application is determined as FAMIS Plus-likely, the application is sent over to the DMAS FAMIS Plus Unit for a Medicaid eligibility determination.

I. DMAS FAMIS Plus Unit Responsibilities and Procedures

FAMIS Plus-likely applications referred to the DMAS FAMIS Plus Unit from the FAMIS CPU are recorded on a daily log. Steps are being taken to allow the DMAS FAMIS Plus Unit to build and transfer applications in ADAPT and MEDPEND. All referred applications are screened for FAMIS Plus eligibility by the DMAS FAMIS Plus Unit. FAMIS Plus-likely applications connected to active cases in ADAPT or MMIS are transferred to LDSS for processing, and notice of the transfer is sent to the family. The application, the verifications, and a copy of the notice are placed in a sealed envelope and transferred to the LDSS via the courier no later than the next business day.

The DMAS FAMIS Plus Unit processes FAMIS Plus-likely applications that have been pending 25 days or more, and transfers enrolled FAMIS Plus cases to the LDSS. If the unit’s screening determines that the application is not FAMIS Plus-likely, then a FAMIS eligibility determination is completed and the case is returned to the FAMIS CPU in an approved or denied status.

FAMIS redeterminations and renewals are also screened for FAMIS Plus eligibility and, if FAMIS Plus-likely, are referred to the DMAS FAMIS Plus Unit. If the FAMIS Plus-likely FAMIS redetermination or renewal is connected to an active case in ADAPT or MMIS, the case is transferred to the LDSS for the FAMIS Plus determination. If the FAMIS Plus-likely FAMIS redetermination/renewal is not connected to an active case, the DMAS FAMIS Plus Unit completes the FAMIS Plus determination and transfers the approved ongoing case to the LDSS.

J. DMAS Contacts at the CPU

The DMAS FAMIS Plus Unit eligibility workers are designated as the liaisons between the LDSS workers and the FAMIS CPU staff. The FAMIS Plus Unit workers are assigned to specific geographic areas. These
assignments were made to improve communication and facilitate resolution to problems involving cases that have been transferred between the CPU and LDSS. The DMAS FAMIS Plus workers are assigned to five geographic areas of the state. The geographic areas correspond to the LDSS regions. The list of the DMAS FAMIS Plus workers and the areas they serve is available on the DSS intranet in the Benefit Programs, Medicaid Eligibility, ME Contacts folder at: http://localagency.dss.virginia.gov/divisions/bp/me/contacts.cgi.

The DMAS FAMIS Plus workers will:

- act as contact persons for cases transferred to the CPU and the LDSS,
- answer non-policy related questions regarding transferring or closing cases, and
- change worker number V0000 to M0000 when necessary.

The DMAS FAMIS Plus workers will not provide policy clarification and will not handle client complaints. Please continue to contact your supervisor or Medical Assistance Program Consultant for assistance with policy clarifications, computer system problems, and client complaints.

Please note that the DMAS FAMIS Plus workers’ telephone numbers are for the LDSS workers only and are not to be given to clients. The CPU has a separate toll-free FAMIS helpline number (1-866-87FAMIS or 1-866-873-2647) designated for client use. This toll-free FAMIS telephone number is not for use by LDSS workers.

K. FAMIS Select

Under the FAMIS program, a family who has access to health insurance through an employer, or wishes to purchase a private policy, has the option of enrolling the family in that health plan. “FAMIS Select” allows the choice of the private or employer’s insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family’s share of the health insurance premium.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

L. 12-Month Continuous Coverage

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for FAMIS Plus or Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in FAMIS Plus or Medicaid.
M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.
<table>
<thead>
<tr>
<th>QUALIFIED ALIEN GROUPS</th>
<th>ARRIVED BEFORE AUGUST 22, 1996</th>
<th>ARRIVED ON OR AFTER AUGUST 22, 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1ST 5 YEARS</td>
<td>AFTER 5 YEARS</td>
</tr>
<tr>
<td>Qualified aliens who are Veterans or Active Military (includes spouses/dependent</td>
<td>Eligible</td>
<td>Eligible</td>
</tr>
<tr>
<td>children); certain American Indians Form DD 214-veteran</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except</td>
<td>Eligible</td>
<td>NOT Eligible</td>
</tr>
<tr>
<td>Anerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)</td>
<td></td>
<td>Eligible</td>
</tr>
<tr>
<td>Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section</td>
<td>Eligible</td>
<td>NOT Eligible</td>
</tr>
<tr>
<td>203(a)(7) of the INA I-94</td>
<td></td>
<td>Eligible</td>
</tr>
<tr>
<td>Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8</td>
<td>Eligible</td>
<td>NOT Eligible</td>
</tr>
<tr>
<td>Battered aliens, alien parents of battered children, alien children of battered</td>
<td>Eligible</td>
<td>NOT Eligible</td>
</tr>
<tr>
<td>parents U.S. Attorney General</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)</td>
<td>Eligible</td>
<td></td>
</tr>
<tr>
<td>Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or</td>
<td>Eligible</td>
<td></td>
</tr>
<tr>
<td>Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of 1980 including those under section 212(d)(5) I-551; I-94; I-688B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3)</td>
<td>Eligible</td>
<td></td>
</tr>
<tr>
<td>of the INA I-688-B – 274a.12(a)(10) Immigration Judge’s Order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victims of a severe form of trafficking pursuant to the Trafficking Victims</td>
<td>Eligible</td>
<td></td>
</tr>
<tr>
<td>Protection Act of 2000 (P.L. 106-386 [ORR certification/eligibility letter]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## UNQUALIFIED ALIEN GROUPS

**NOT ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE**

<table>
<thead>
<tr>
<th>Description</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)</td>
<td></td>
</tr>
<tr>
<td>Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>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))</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>Aliens residing in the U.S. under orders of supervision (I-220B)</td>
<td></td>
</tr>
<tr>
<td>Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
</tbody>
</table>
A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 166% of the federal poverty level (FPL). An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

FAMIS MOMS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The DMAS will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS MOMS is determined by local departments of social services (LDSS), including LDSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Case management and ongoing case maintenance, and selections for managed care, are handled by the FAMIS CPU.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 166% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- she is a resident of Virginia;
- she is uninsured;
- she is not a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member’s employment with a State agency (see Appendix 3 to Chapter M21 for a list of state agencies);
- she is not an inmate of a public institution;
• she is not an inpatient in an institution for mental diseases; and
• she has countable family income less than or equal to 166% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Policy
The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Applicable Requirements
The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

• Virginia residency requirements;
• assignment of rights;
• application for other benefits;
• institutional status requirements regarding inmates of a public institution.

C. FAMIS Nonfinancial Requirements
The FAMIS nonfinancial eligibility requirements are:

1. Citizenship & Alienage
   Requirements
   FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.

   a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.

   b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements without any time limitations:

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

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

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

5. Insured means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

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

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman cannot:

• have creditable health insurance coverage;
• have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.);
• be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to chapter M21].

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.
M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. FAMIS MOMS Assistance Unit
   The FAMIS MOMS assistance unit policy is the same as the Medicaid pregnant woman assistance unit policy. Use subchapter M0520, F&C Family/Budget Unit, to determine the pregnant woman’s family unit for her financial eligibility determination. If ineligible in the family unit, determine her eligibility in the budget unit (if appropriate).

2. Asset Transfer
   Asset transfer rules do not apply to FAMIS MOMS.

3. Resources
   Resources are not evaluated for FAMIS MOMS.

4. Income
   The FAMIS MOMS income limit is 166% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS MOMS family unit, and budget unit (if applicable).

   The source and amount of all income other than Workforce Investment Act and student income, must be verified and counted. FAMIS MOMS uses the same income types and methods for estimating income as in Medicaid Families & Children (F&C) policy (see chapter M07).

   Medicaid F&C income disregards, other than the $30 plus 1/3 earnings disregard in LIFC, apply when determining countable income for FAMIS MOMS (see chapter M07).

5. No Spenddown
   Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program and she must be given the opportunity to have a medically needy (MN) Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements
   The following forms are acceptable application forms for FAMIS MOMS:
   - Health Insurance for Children and Pregnant Women application,
   - Medicaid Application for Medically Indigent Pregnant Women
   - Application for Benefits, and
   - ADAPT Statement of Facts.

   Applications can be mailed to the LDSS or the FAMIS Central Processing Unit (CPU). A face-to-face interview is not required.

   The date of the application is the date the signed application is received at the LDSS, including DSS outstationed sites, or at the FAMIS CPU.
## FAMIS MOMS
### INCOME LIMITS
#### ALL LOCALITIES

**EFFECTIVE 9/01/2006**

<table>
<thead>
<tr>
<th># of Persons in FAMIS MOMS Assistance Unit</th>
<th>FAMIS MOMS 166% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual Limit</td>
</tr>
<tr>
<td>1</td>
<td>$16,268</td>
</tr>
<tr>
<td>2</td>
<td>21,912</td>
</tr>
<tr>
<td>3</td>
<td>27,556</td>
</tr>
<tr>
<td>4</td>
<td>33,200</td>
</tr>
<tr>
<td>5</td>
<td>38,844</td>
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<tr>
<td>6</td>
<td>44,488</td>
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<tr>
<td>7</td>
<td>50,132</td>
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<tr>
<td>8</td>
<td>55,776</td>
</tr>
<tr>
<td>Each Additional</td>
<td>5,644</td>
</tr>
</tbody>
</table>