

AFFIDAVIT OF UNITED STATES CITIZENSHIP OR LEGAL PRESENCE IN THE UNITED STATES ...2
AGREEMENT TO SELL NON-LIQUID RESOURCES3
CONDITIONAL BENEFITS NOTICE.....5
ELIGIBILITY COMMUNICATION DOCUMENT10
ELIGIBILITY WORKER REFERRAL12
NOTICE OF ACTION (FOR AG)13
PROVIDER/DSS COMMUNICATION FORM.....16
TRANSFER OF RESOURCES NOTICE19
STATEMENT OF FUNDS YOU PROVIDED TO ANOTHER.....26
BURIAL RESOURCE STATEMENT.....27
STATEMENT OF VIRGINIA RESIDENCY AND INTENT TO REMAIN IN VIRGINIA28

08/15



COMMONWEALTH of VIRGINIA

AFFIDAVIT OF UNITED STATES CITIZENSHIP OR LEGAL PRESENCE IN THE UNITED STATES

I understand that providing proof of my United States citizenship or legal presence in the United States is a requirement for receipt of Virginia Medicaid benefits. I declare, under penalty of perjury, that I am a United States citizen or am legally present in the United States.

I understand that if I give false information regarding my United States citizenship or legal presence in the United States, my Virginia Medicaid coverage may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

Print Name _____

Signature _____ Date _____

Residence Address _____ Telephone _____

City _____ State _____ ZIP _____

08/15

AGREEMENT TO SELL NON-LIQUID RESOURCES			APPLICANT CASE NUMBER		
APPLICANT					
<p>CONDITIONS OF AGREEMENT: My resources exceed the amount which an eligible individual may have and still qualify for Auxiliary Grant payments. I hereby request that conditional payments be made to me until I can sell the below described resources at their current market value. Once the local department of social services notifies me that this agreement has been approved, I agree to sell the resources described below for the highest price I can get and to do so within 3 months (for personal property) or 9 months (for real property) of being notified that the agreement is approved.</p> <p>I also agree to notify the LDSS within 5 working days after I complete the sale. I further agree to repay immediately all payments I have received that would not have been paid if I had sold the resources described below the day I filed application for benefits.</p> <p>I further understand that if I fail to comply with the terms of this agreement, I will be required to make immediate refund of all Conditional Benefits payments I received. <i>(Read the information on the back of this form.)</i></p>					
DESCRIPTION OF EACH RESOURCE IF REAL PROPERTY, SHOW ADDRESS OR LOCATION	NAMES OF OWNERS	TYPE AND PERCENTAGE OF OWNERSHIP OF EACH	ESTIMATED CURRENT MARKET VALUE	AMOUNT OWED ON RESOURCE IF ANY	NUMBER OF MONTHS IN DISPOSAL PERIOD
1.					
2.					
3.					
4.					
SIGNATURE	ADDRESS (STREET & NO.)	CITY, STATE AND ZIP CODE			DATE

08/15

**AGREEMENT TO SELL NON-LIQUID RESOURCES
IMPORTANT INFORMATION ABOUT THIS AGREEMENT**

I. TIME LIMITS FOR SELLING PROPERTY

The time limit during which you must sell the property is:

Real Property (Houses, Land, etc.) – 9 months from the date this agreement is approved.

All Other Property - 3 months from the date this agreement is approved.

Notify your Local Department of Social Services (LDSS) immediately if you find you are unable to sell the property within this time limit.

II. CURRENT MARKET VALUE

When you sign the other side of this form, you agree to sell the resources described there for their current market value. This means the highest amount you can get by offering it on the open market.

If you knowingly dispose of an agreed-upon resource for less than its current market value, the LDSS will determine what the current market value was at the time of disposition and determine the amount of your overpayment accordingly.

III. NOTIFYING YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES

Notify your LDSS office within five days after you sell the property. Also notify your LDSS immediately if you encounter difficulty in selling the property or if you decide not to sell the property.

08/15

COMMONWEALTH OF VIRGINIA
DEPARTMENT FOR AGING AND REHABILITATIVE
SERVICES
AUXILIARY GRANT PROGRAM

County/City: _____

Case Number: _____

Date Mailed: _____

CONDITIONAL BENEFITS NOTICE

To:

This is to notify you of the action taken by the department of social services. Please look at the block or blocks checked below. The statements following the checked blocks apply to you.

A copy of this notice is being sent to: _____

You have been found ineligible for regular Auxiliary Grant benefits solely due to excess non-liquid resources (real or personal property). However you may qualify for Auxiliary Grant Conditional Benefits for a period of time if you agree to dispose of your excess non-liquid resources and to repay any Conditional Benefits you receive. An "Auxiliary Grant Conditional Benefits Fact Sheet" is attached.

If you wish to receive Conditional Benefits, complete and return the attached "Agreement To Sell Non-Liquid Resources" form to this agency by _____. If you do not wish to receive the Conditional Benefits, please submit a written statement to that effect.

Failure to return the "Agreement To Sell Non-Liquid Resources" form or the written statement by the above date will be taken as your refusal to accept conditional benefits and your Auxiliary Grant application will be denied due to excess resources.

Your signed "Agreement To Sell Non-Liquid Resources" has been received and accepted. You are eligible for Auxiliary Grant Conditional Benefits. You will be eligible for Conditional Benefits for a maximum of _____ months beginning _____.

You will receive _____ per month until your amount of income or resources change or you are no longer eligible for Conditional Benefits.

You have agreed to dispose of your excess non-liquid resources, receive Auxiliary Grant Conditional Benefits, and pay back an amount equal to the Conditional Benefits you will receive. You will be required to repay the Conditional Benefits at the point you sell your non-liquid resources or are no longer eligible for Conditional Benefits.

You must take action to put your property on the market and provide verification of how you are advertising it to the local department of social services by _____. Your asking price cannot exceed the current market value of the property. You may:

- List the property with an agent; or
- Begin to advertise in at least one of the appropriate media; place a "For Sale" sign on the property (if permitted); begin to conduct open houses or otherwise show the property to interested parties on a continuing basis; or attempt any other appropriate methods of sale such as posting notices on community bulletin boards, distributing fliers, etc.

You must maintain your efforts to sell your property throughout your disposal period. You will be contacted every 30 to 60 days to confirm that you maintaining your efforts to sell.

You MUST ACCEPT any reasonable offer to buy your property. If you reject an offer, you must demonstrate to the local department of social services that the offer was not reasonable.

You must report the sale of your real or personal property within five days after the property has been sold. Working days are Monday through Friday and do not include Federal holidays.

You have a set period of time to dispose of your excess real or personal property and to thereby reduce your total countable resources to \$2000 or less. Your disposal periods are noted below.

Non-Liquid Resources	Current Market Value	Disposal Period

As a recipient of Conditional Benefits, you are required to use your income and the Auxiliary Grant to pay the assisted living facility or adult foster care home in which you live for your basic care. The amount you are to pay for your basic care is \$ _____.

In addition, the assisted living facility or adult foster care home may charge you up to \$10 a month for laundry and other amounts for personal expenses such as long distance phone calls. The facility/home is required to notify you in advance of any additional charges.

Any money that remains after you have paid the facility/home is yours to use to meet any other expenses you may have.

Your eligibility for Conditional Benefits has ended and your case will be closed effective _____.

Your disposal period ended and you continue to have excess resources. You will be evaluated for regular Auxiliary Grant eligibility. Manual Reference - _____

The proceeds from the sale of your non-liquid resources plus your other countable resources exceed the resource limit. Manual Reference - _____

You withdrew your agreement to sell your excess non-liquid resources. Manual Reference - _____

You failed to maintain reasonable effort to sell your excess non-liquid resources. Manual Reference - _____

The amount of your Conditional Benefits overpayment will be computed based on the current market value of your resources. If the value of any of your resources differs from the CMV, you may submit proof of that value to the local department of social services.

Your Non-Liquid Resources Include:	Current Market Value

The amount of your Conditional Benefits overpayment is _____. This amount is due and payable now. **Please contact the local department of social services for instructions on the repayment process.**

If you disagree with the action taken, you may ask for a conference with your worker whose name, address, and telephone number appear on the bottom of the page or ask for a fair hearing before the Virginia Department of Social Services. The information attached explains your right to appeal and **explains how to ask for a fair hearing.**

If you are eligible for assistance, the law requires you to notify this department timely of any change in your income, resources, support, living arrangements, or other circumstances which would affect your eligibility or the amount of assistance. **The sale of resources must be reported within five days. Other changes must be reported within 10 days after the change occurs.**

ELIGIBILITY WORKER	TELEPHONE NUMBER	DATE OF MAILING	IF YOU WANT FREE LEGAL ADVICE CALL _____
MAILING ADDRESS:			(This number is a local legal services agency, not the department of social services.)

08/15

APPEALS AND FAIR HEARINGS

A fair hearing provides you the opportunity to review the way a local department of social services has handled your situation concerning your stated need for financial assistance. The fair hearing process is a private, informal meeting at the local department of social services with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

If you disagree with the action taken, you may request in writing, to appeal the decision and receive a fair hearing. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer or appropriate authority will decide if you are right. Appeals should be sent to:

Manager, Appeals and Fair Hearings
Virginia Department of Social Services
801 E. Main Street
Richmond, Virginia 23219-1849

The person who conducts the hearing is someone from the State Department of Social Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local department of social services or at a location agreeable to you and the agency. If you cannot be there on that day, call your service or eligibility worker immediately. If you need transportation, the local department of social services will provide it. You may bring a representative and/or witness to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

- (1) examine all documents and records which are used at the hearing;
- (2) present your case or have it presented by a lawyer or by another authorized representative;
- (3) bring witnesses;
- (4) establish pertinent facts and advance arguments; and
- (5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local department of social services would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 60 days of the date your appeal request is received by the local or State Department of Social Services.

08/15

Virginia Department for Aging and Rehabilitative Services
Auxiliary Grant Program
Conditional Benefits Fact Sheet

An individual who is ineligible for a regular Auxiliary Grant (AG) payment due to excess **non-liquid resources** may qualify for AG Conditional Benefits if the individual meets all other eligibility requirements and agrees to sell the excess resources.

Non-Liquid Resources

Non-liquid resources are resources which are not in the form of cash and cannot be converted to cash within 20 workdays. Both real property and personal property may be classified as non-liquid resources.

Workdays are any days other than Saturdays, Sundays, and Federal holidays.

Exclusion of Non-Liquid Resources

AG policy provides for an exclusion of excess non-liquid resources for a set period of time if the individual agrees to take action to dispose of the excess non-liquid resources and to repay the amount of the AG Conditional Benefits he/she will receive during the disposal period. The AG benefits paid during the period the exclusion is applied are Conditional Benefits, benefits paid on the condition they be repaid.

Conditional Benefits are basically an “advance” to the individual, one that must be repaid from the proceeds of the sale of the excess resources. In this manner, the individual is permitted to use his/her own resources to meet his/her needs. Conditional Benefits differ from regular AG benefits only in that they must be repaid.

Individual’s Choice

An individual must choose whether to accept Conditional Benefits. Refundable AG benefits are possible for a limited number of months if the individual agrees in writing to:

- Sell certain property within a specified disposal period;
- Sell the property for as much as he/she can within the disposal period, while asking no more than the current market value (CMV) as estimated by a knowledgeable and disinterested third party;
- Notify the local department of social services worker within 5 days of the sale of the resource; and
- Repay the Conditional Benefits paid during the disposal period at the point the property is sold or the disposal period ends.

The agreement becomes effective on the date the individual receives written notice that the agreement has been approved.

AG Payment

The first AG Conditional Benefit payment will be issued for the month after the month the agreement becomes effective. Payment cannot be made for any month before the agreement takes effect or in the month the agreement takes effect.

Disposal/Exclusion Period

08/15

The individual that chooses to accept Conditional Benefits is allowed a set period of time to dispose of his/her excess non-liquid resources. The disposal period and the exclusion period are one and the same. The length of the disposal period is determined by the type of non-liquid resource that must be disposed.

The periods for the disposal of excess non-liquid resources are:

- 9 months for real property;
 - There is no extension of the disposal period for real property.
- 3 months for personal property.
 - One 3-month extension for disposition of personal property is permitted if good cause exists.

The disposal/exclusion period begins on the date the worker “accepts” the individual's signed written agreement, the Agreement to Sell Non-Liquid Resources. The date of acceptance is the date the notice is handed to the individual or 5 days from the date the notice is mailed.

Reasonable Effort to Sell

The individual must make a reasonable effort to sell his excess non-liquid resources throughout the disposal period. Within 30 days of signing a Conditional Benefits agreement, the owner must:

- List the property with an agent; or
- Begin to advertise in at least one of the appropriate media; place a “For Sale” sign on the property (if permitted); begin to conduct open houses or otherwise show the property to interested parties on a continuing basis; or attempt any other appropriate methods of sale such as posting notices on community bulletin boards, distributing fliers, etc.

Except for gaps of no more than 1 week, the owner must maintain efforts of the type listed above.

The owner must not reject any reasonable offer to buy the property. An offer to buy real property is reasonable if it is at least two-thirds of the estimated CMV unless the owner proves otherwise.

08/15

**VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
ASSISTED LIVING FACILITY/ADULT FOSTER CARE HOME**

ELIGIBILITY COMMUNICATION DOCUMENT

To/From: Dept. of Social Services Eligibility Worker in _____
(City/County Responsible for Auxiliary Grant)

Address: _____

To/From: _____
(ALF Assessor/Case Manager)

Address: _____

Assessor's provider #: _____

RESIDENT: _____ **SSN:** _____

ALF/AFCH and Location: _____

Medicaid #: _____

PURPOSE OF COMMUNICATION (check 1, 2, or 3):

- 1. ANNUAL REASSESSMENT COMPLETED; Date of Reassessment: __/__/__**
 - a. **Resident Continues to Meet Criteria for ALF/AFCH Placement at the following level of care:**
 - Residential Living Assisted Living
 - b. **Resident Does Not Meet Criteria for Residential, Assisted Living, or AAL Waiver**
- 2. RESIDENT NO LONGER RESIDES IN ALF/AFCH ON RECORD.** Resident has been discharged to:
 - a. **Another ALF/AFCH.** Last Date of Service in the ALF/AFCH on Record: __/__/__
 Name of New ALF/AFCH : _____
 Provider #: _____ Start of Care Date in New ALF/AFCH: __/__/__
 Address of New ALF/AFCH: _____
 - b. **Home.** Last Date of Service in the ALF/AFCH: __/__/__
 New Address: _____
 - c. **Other** (please specify): _____
 Last Date of Service in the ALF/AFCH: __/__/__
 New address: _____
- 3. AUXILIARY GRANT ELIGIBILITY TERMINATED** Effective Date: __/__/__
 Reason: _____

<i>(Name of Assessor/Case Manager Completing Form)</i>		<i>(Name of Eligibility Worker Completing Form)</i>	
<i>(Signature of Assessor/Case Manager Completing Form)</i>		<i>(Signature of Eligibility Worker Completing Form)</i>	
<i>(Date)</i>	<i>(Telephone No.)</i>	<i>(Date)</i>	<i>(Telephone No.)</i>

ALF/AFCH ELIGIBILITY COMMUNICATION DOCUMENT INSTRUCTIONS***WHEN TO USE THIS FORM***

This form is a communication tool between the local department of social services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the assisted living facility (ALF) resident, Adult Foster Care Home and DMAS. This form is completed by:

1. The assessor to the eligibility worker and to DMAS at the time of a 12-month reassessment (a finding that the resident continues to meet either residential or assisted living is required in order for the eligibility worker to redetermine eligibility for an Auxiliary Grant (AG) payment);
2. Either the assessor or eligibility worker to the other and to DMAS whenever either becomes aware of a change in address; and
3. The eligibility worker to the ALF/AFCH assessor and to DMAS whenever the AG is terminated.

TO/FROM SECTION

Both TO/FROM sections must be completed. Completely fill in the locality of the DSS eligibility worker with address and indicate whether document is to be sent to or from the eligibility worker by circling "TO" or "FROM." In the second TO/FROM section, completely fill in the assessor's name, address and provider number and indicate whether the document is to be sent to or from the assessor or case manager by circling "TO" or "FROM."

RESIDENT IDENTIFICATION SECTION

1. RESIDENT: Legibly print name of ALF/AFCH resident who is being assessed, who has moved, or whose AG has been terminated.
2. SSN: Write in the resident's social security number.
3. ALF: Legibly print the name of the ALF in which the resident resides or the AFCH.
4. Facility location: List the city/town in which the ALF or AFCH is located.
5. Medicaid Number: Write in the resident's Medicaid number.

PURPOSE OF COMMUNICATION SECTION: Check 1, 2, or 3.

If 1 is checked: (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. (Resident continues to meet criteria for ALF/AFCH placement at the following level of care) or b. (Resident does not meet criteria for residential or assisted living. If a. is checked, indicate which level of care the individual meets. When 1 is checked, the non- DSS assessor sends a copy of the Uniform Assessment Instrument (UAI), the ALF Eligibility Communication Document (ECD) to Xerox and file HCFA-1500 online to Xerox. Local DSS workers do not send anything to Xerox but completes CMS 1500 on-line. In addition, ALL assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ALF; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents.

NOTE: If a reassessment indicates a change in level of care, treat the assessment as a change in level of care. That is, send a copy of the UAI and the DMAS-96 to DMAS. In addition, send the eligibility worker a copy of the DMAS-96; send to the ALF copies of the UAI, DMAS-96, and decision letter; and send a decision letter to the individual being assessed. The assessor should keep a copy of each.

If 2 is checked: (Resident no longer resides in ALF/AFCH on record), indicate to where the resident moved (i.e., another ALF, AFCH, home, or other). For each, indicate the last date of service in the ALF/AFCH on record. Complete other information such as new address, etc., if known. When 2 is checked, the assessor/case manager or eligibility worker completing the ECD should send a copy to the other and a copy to DMAS and keep a copy for him- or herself.

If 3 is checked: (Auxiliary Grant Eligibility Terminated), the eligibility worker indicates the effective date of termination and the reason. Then the eligibility worker sends a copy of the ECD to the assessor/case manager and to DMAS.

SIGNATURES SECTION

For each form completed, only one signature section will be completed. For example, if an assessor is completing the form for a reassessment, the left-hand side with assessor information will be completed. If the eligibility worker is completing the form for notification of AG eligibility termination, then the right-hand side is completed. Please completely fill in the applicable section with printed name of individual completing the form, signature, complete date with month/day/year, and telephone number with area code.

Please photocopy this form as needed; plain paper copies are acceptable.

08/15

Medicaid Referral to APS to Request Assessment for Guardianship

ELIGIBILITY WORKER REFERRAL

Date _____

From _____ Worker # _____ Telephone # _____
(Eligibility Worker)

To _____
(Adult Protective Services Worker/Supervisor)

The adult listed below does not have a power of attorney, guardian, conservator, or family substitute member. This adult does not appear capable of understanding, completing and signing an application/redetermination form for Medicaid.

Name _____

SSN _____

Date of Birth _____

Medicaid ID Number

Home Address

Current Location

Is this adult currently in a hospital, nursing facility, or adult living facility?

Yes _____

No _____

If yes, name of the facility _____

Contact Person _____

Address of the facility _____

Telephone number of the facility _____

***THIS FORM MAY BE DUPLICATED.**

08/15

COMMONWEALTH OF VIRGINIA
 DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
 AUXILIARY GRANT

County/City:

Case Number:

NOTICE OF ACTION (for AG)

<p>To:</p>	<p>This is to notify you of the action taken by the department. Please review the block or blocks checked below. The statements following the checked blocks apply to you.</p> <p>A copy of this notice is being sent to:</p>						
<p><input type="checkbox"/> Your application for an Auxiliary Grant was approved on _____ effective _____.</p> <p>You will receive one AG payment that will include your payment for the following prior months: \$ _____ for the month of _____ \$ _____ for the month of _____ \$ _____ for the month of _____</p> <p style="text-align: center;">\$ Total Payment for Prior Months</p>							
<p><input type="checkbox"/> Beginning _____, you will receive a payment near the beginning of each month in the amount of \$ _____. This amount will be sent to you each month until you have a change in your income, resources, or your residence.</p>							
<p><input type="checkbox"/> As an Auxiliary Grant recipient you are required to use your income and the Auxiliary Grant to pay the assisted living facility or adult foster care home in which you live for your basic care. The amount you are to pay for your basic care is \$ _____.</p> <p>In addition, the assisted living facility or adult foster care home may charge you up to \$10 a month for laundry and other amounts for personal expenses such as long distance phone calls. The facility/home is required to notify you in advance of any additional charges.</p> <p>Any money that remains after you have paid the facility/home is yours to use to meet any other expenses you may have.</p>							
<p><input type="checkbox"/> You were approved for Medicaid effective _____.</p>							
<p><input type="checkbox"/> Your application for Medicaid was DENIED on _____.</p> <p>Reason: _____ Manual Reference: _____</p>							
<p><input type="checkbox"/> Your application for an Auxiliary Grant was DENIED on _____.</p> <p>Reason: _____ Manual Reference: _____</p> <p>made on _____</p>							
<p><input type="checkbox"/> Action was not taken on your application for assistance within 45 days after it was made on _____</p>							
<p><input type="checkbox"/> Your grant was increased</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">From:</td> <td style="width: 30%;">To:</td> <td style="width: 40%;">Beginning date:</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>	From:	To:	Beginning date:			
From:	To:	Beginning date:					
<p><input type="checkbox"/> Your grant was reinstated</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Amount:</td> <td style="width: 60%;">Beginning date:</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	Amount:	Beginning date:				
Amount:	Beginning date:						
<p><input type="checkbox"/> Your annual redetermination was completed and you continue to be eligible.</p>							
<p><input type="checkbox"/> Reduced <input type="checkbox"/> Suspended <input type="checkbox"/> Terminated Effective Date: _____ Manual Reference: _____</p>							

08/15

Reason for proposed action:			
<input type="checkbox"/> Your application was denied because you transferred a resource for less than its current market value. See the attached "TRANSFER OF RESOURCES" notice.			
<input type="checkbox"/> Other Reason for action or failure to act:			
If you disagree with the action taken, you may ask for a conference with your worker whose name, address, and telephone number appear on the bottom of the page or ask for a fair hearing before the Virginia Department of Social Services. The information on the second page of this form explains your right to appeal and <u>explains how to ask for a fair hearing.</u>			
If you are eligible for assistance, the law requires you to notify this department timely of any change in your income, resources, support, living arrangements, or other circumstances which would affect your eligibility or the amount of assistance. <u>Changes must be reported within 10 days after the change occurs.</u>			
ELIGIBILITY WORKER	TELEPHONE NUMBER	DATE OF MAILING	IF YOU WANT FREE LEGAL ADVICE CALL
MAILING ADDRESS:			THIS NUMBER IS A LOCAL LEGAL SERVICES AGENCY, NOT THE DEPARTMENT OF SOCIAL SERVICES

032-15-0001-03 eng (8/15)

08/15

APPEALS AND FAIR HEARINGS

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for financial assistance. The fair hearing process is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

If you disagree with the action taken, you may request in writing, to appeal the decision and receive a fair hearing. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer or appropriate authority will decide if you are right. Appeals should be sent to:

Manager, Appeals and Fair Hearings
Virginia Department of Social Services
801 E. Main Street
Richmond, Virginia 23219-1849

The person who conducts the hearing is someone from the State Department of Social Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witness to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

- (1) examine all documents and records which are used at the hearing;
- (2) present your case or have it presented by a lawyer or by another authorized representative;
- (3) bring witnesses;
- (4) establish pertinent facts and advance arguments; and
- (5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 60 days of the date your appeal request is received by the local or State Department of Social Services.

08/15

**VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
AUXILIARY GRANT PROGRAM**

PROVIDER/DSS COMMUNICATION FORM

AG Case Number: _____ **Provider Name** _____

Recipient

Name: _____ **SSN:** _____ **DOB:** _____

Address: _____

Medicaid ID: _____

Section I - Provider Completes This Section

Patient Status (Complete Appropriate Blocks. (Report any admission, discharge, and/or change in patient status.)

Patient admitted to this assisted living facility/adult foster care home on _____ (date)

Level of care: Residential Assisted Living

Patient discharged or expired on _____ (date)

Discharged to: Home Hospital Other Facility Expired

Case is in need of an assessment

Patient's income or deductions have changed

Other: Explain _____

Prepared by Name: _____ Title: _____

Telephone: _____ Date: _____

Section II - DSS Completes This Section

Eligibility Information:

Auxiliary Grant approved beginning _____ (date)

Medicaid approved beginning _____ (date)

Auxiliary Grant denied effective _____ (date)

Ineligible for Auxiliary Grant from _____ to _____ due to a resource transfer.

08/15

Approved AG Rate

NOTE: ALF/AFCH providers cannot collect more than the AG rate from the patient. Any income received by the patient in excess of the AG rate is to be retained by the patient. The amount a patient will normally retain will exceed his/her personal needs allowance.

ALF/AFCH Rate: _____ for month of _____ .

ALF/AFCH Rate: _____ for month of _____ .

Worker Name: _____ Agency Name: _____

Agency Address: _____

Telephone: _____ Date: _____

08/15

PROVIDER/DSS COMMUNICATION FORM
Instructions

PURPOSE OF FORM--To allow the local DSS and the assisted living facility or adult foster care home provider to exchange information regarding:

1. The AG and Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. Admission or discharge of a patient to home, hospital, another ALF/AFCH, or an institution, or to report the death of a patient;
4. Other information known to the provider that might cause a change in the eligibility status.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each applicant at the time initial eligibility is determined. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in the patient's ineligibility.

The provider must use the form to show admission date, to request an AG or Medicaid eligibility status, to request a Medicaid recipient I.D., to notify the local DSS of changes in the patient's circumstances, of discharge or death.

NUMBER OF COPIES--Original and one copy.

DISTRIBUTION OF COPIES--Send the original to the facility and file the copy in the eligibility case folder.

INSTRUCTIONS FOR PREPARATION OF THE FORM-- Complete the heading with the name of the AG Case Number, Provider Name, Recipient Name, Social Security Number, Date of Birth, the address, and Medicaid I.D. Number.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Section II - Eligibility Information:

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of the Auxiliary Grant.
2. Check the second block if the individual is eligible for Medicaid.
3. Check the third block if the Auxiliary Grant was denied.
4. Check the fourth block if ineligible for AG due to transfer of resources. Dates of disqualification must be listed on the form.

AG Rate:

Enter the amount of the ALF/AFCH rate, and month and year in which the rate is effective. Fill in Worker Name, Agency Name, Telephone Number and Date the form was completed.

08/15

COMMONWEALTH OF VIRGINIA
 DEPARTMENT OF AGING AND REHABILITATIVE
 SERVICES
 AUXILIARY GRANT

County/City: _____
 Case Number: [_____

Case Number: _____

TRANSFER OF RESOURCES NOTICE

To:

This is to notify you of the action taken by the department of social services. Please look at the block or blocks checked below. The statements following the checked blocks apply to you.

A copy of this notice is being sent to: _____

You transferred a resource or resources for less than the current market value. Based on the value of the transferred items, it has been determined that you are ineligible for an Auxiliary Grant payment from _____ through _____.

Item Transferred	Date Transferred	Current Market Value	Value Received	Uncompensated Value
			Total Uncompensated Value	
Your period of ineligibility was determined by dividing the total uncompensated value by the ALF/AFCH monthly rate for your area.			ALF/AFCH Rate:	# Months in Period of Ineligibility:

If you will not be able to purchase food or shelter without the Auxiliary Grant, you may claim a hardship exemption. If it is found that not receiving AG would be a hardship to you in any month, that month will not be included in your period of ineligibility. To claim a hardship exemption, submit a written request that states that:

- Lack of AG payments will cause you a loss of food or shelter; you do not expect an increase in income or resources within the ineligibility period; you will promptly report any changes in income and resources; and that you may have to repay any AG benefits issued for any month where hardship did not exist.

Your period of ineligibility due to your transfer of resources has been reevaluated and adjusted. It has been determined that you are ineligible for an Auxiliary Grant payment from _____ through _____.

Item Transferred:	Date Transferred	Market Value	Value Received	Uncompensated Value
			Total Uncompensated Value	
Your period of ineligibility was determined by dividing the total uncompensated value by the ALF/AFCH for your area.			ALF/AFCH Rate:	# Months in Period of Ineligibility:

You filed a hardship claim stating that you would not be able to purchase food or shelter without the receipt of an Auxiliary Grant payment. Your claim has been evaluated. See the result below:

<input type="checkbox"/> Your hardship claim was denied. Your income and resources are sufficient to meet	<input type="checkbox"/> Your hardship claim was approved for the following months:	<input type="checkbox"/> You will be contacted periodically to determine if
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08/15

your food and shelter needs.		hardship continues to exist.	
<p>If you disagree with the action taken, you may ask for a conference with your worker whose name, address, and telephone number appear on the bottom of the page or ask for a fair hearing before the Virginia Department of Social Services. The information below explains your right to appeal and <u>explains how to ask for a fair hearing.</u></p> <p>If you are eligible for assistance, the law requires you to notify this department timely of any change in your income, resources, support, living arrangements, or other circumstances which would affect your eligibility or the amount of assistance. <u>Changes must be reported within 10 days after the change occurs.</u></p>			
ELIGIBILITY WORKER	TELEPHONE NUMBER:	DATE OF MAILING	IF YOU WANT FREE LEGAL ADVICE CALL :
MAILING ADDRESS:			(THIS NUMBER IS NOT THE DEPARTMENT OF SOCIAL SERVICES.)

08/15

APPEALS AND FAIR HEARINGS

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for financial assistance. The fair hearing process is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearing officer. The hearing officer is the official representative of the State Department of Social Services.

If you disagree with the action taken, you may request in writing, to appeal the decision and receive a fair hearing. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer or appropriate authority will decide if you are right. Appeals should be sent to:

Manager, Appeals and Fair Hearings
Virginia Department of Social Services
801 E. Main Street
Richmond, Virginia 23219-1849

The person who conducts the hearing is someone from the State Department of Social Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witness to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

- (1) examine all documents and records which are used at the hearing;
- (2) present your case or have it presented by a lawyer or by another authorized representative;
- (3) bring witnesses;
- (4) establish pertinent facts and advance arguments; and
- (5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 60 days of the date your appeal request is received by the local or State Department of Social Services.

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES**Auxiliary Grant (AG) Program****Transfer of Resources Fact Sheet**

A resource transfer occurs when the ownership of a resource is transferred to another person, trust, or entity. The change of ownership may be accomplished by deed, selling, giving away, trading, or other methods. Resources include money in the bank, certificates of deposit, real property, automobiles, etc.

Impact On AG Eligibility

All transfers made by an AG applicant or recipient within 36 months prior to the date of application for AG, or while receiving AG, must be reported, verified, and evaluated.

If an individual receives adequate compensation for a transferred resource or if the transfer is a type permitted by AG policy, AG eligibility is not impacted. Adequate compensation is the full current market value of the resource.

Transfer for less than the current market value means giving a resource away or selling it to anyone, including family members, for less than it would bring on the open market.

The transfer of resources for less than the current market value could make an individual ineligible for an Auxiliary Grant (AG) payment for a period of time.

Period of Ineligibility

The period of time an individual will be ineligible to receive an AG payment will be based upon the uncompensated value of the transferred resource. Uncompensated value is the difference between the current market value of the resource and the amount the individual received for it.

The uncompensated value divided by the monthly AG rate for the area in which the individual lived at the time of the transfer and rounded down to the next whole number, is the number of months in the ineligibility period. The ineligibility period begins on the first day of the month following the month in which the resource was transferred.

08/15

The following chart shows the AG rates to be used to determine the ineligibility period for a transfer of resources.

MONTHLY MAXIMUM AUXILIARY GRANT RATE HISTORY								
2010-2015								
ALF & AFCH Rates	01/10	01/11	01/12	07/12	01/13	07/13	01/14	01/15
Planning District 8	\$1,279	\$1,279	\$1,303	\$1,317	\$1,303	\$1,375	\$1,388	\$1,402
All Other Districts	\$1,112	\$1,112	\$1,136	\$1,150	\$1,136	\$1,196	\$1,207	\$1,219

Example: An individual living in Virginia Beach (not Planning District 8) transferred a resource for less than the current market value in July 2010. His uncompensated value was \$22,400. The individual’s period of ineligibility for AG is computed by dividing the uncompensated value by the AG rate effective in July 2010, \$1,279.

$$\$22,400 \div \$1,279 = 17.51 \text{ months} = \text{An ineligibility period of 17 months beginning August 1, 2010.}$$

Undue Hardship

If a resource has been transferred and the denial of AG would be an "undue hardship" for the individual, there may not be a penalty. The individual must request an undue hardship exemption and submit evidence to prove the undue hardship claim. "Undue hardship" is defined by AG regulations, as when an individual alleges that failure to receive AG payments would deprive them of food or shelter **and** the individual’s total available income and resources do not equal or exceed the assisted living facility’s or adult foster care home’s rate for the month that undue hardship is alleged.

08/15

Signature	Date	Telephone
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**DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
Auxiliary Grant Program**

STATEMENT OF FUNDS YOU PROVIDED TO ANOTHER

Name of Applicant:	Case Number:	
1. How much money did you provide to the person named above? Amount \$ _____		
2. When did you provide the money? _____(month/year)		
3. Do you expect him/her to pay this money back to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Has he/she begun to repay the money? <input type="checkbox"/> Yes If 'yes', when did you receive the first payment? _____ (month/year) <input type="checkbox"/> No If 'no', when will payments begin? _____ (month/year)		
5. How much are the payments or will the payments be when repayment begins? \$ _____		
6. How often do/will you receive payments? _____		
7. Did he/she promise to give up any property if he/she does not keep up the payments? <input type="checkbox"/> Yes If 'yes' what? _____ <input type="checkbox"/> No		
8. Are you charging interest? <input type="checkbox"/> Yes If 'yes', go to Question # 9. <input type="checkbox"/> No If 'no', sign and date this form and return to the worker.		
9. How much is the interest payment? \$ _____ How often do you receive interest? _____		
Remarks:		
I hereby certify that all information provided on this form is true and correct:		
Name (Print):	Signature:	Date:
Mailing Address		Phone Number (include area code):

DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

AUXILIARY GRANT PROGRAM

BURIAL RESOURCE STATEMENT

CASE NAME:	CASE NUMBER:
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List Resources Designated as Funds for Burial: _____

Name of Individual Funds are Designated for: _____

Date Designated: _____

I understand that I must keep the designated funds separate from non-burial resources.

I also understand that use of any of the excluded burial funds for a purpose other than the burial for which they are intended may mean that future Auxiliary Grant payments will be withheld. If funds are misspent, and at the beginning of the month in which the funds are spent the total of countable resources and excluded burial funds exceed the AG resource limit, any future AG payments will be withheld until the Department of Social Services has recovered the amount of misspent burial funds.

I agree to report to the Department of Social Services:

- Any use of burial funds for a purpose not related to the burial of the individual for whom they were designated. (This includes withdrawals or borrowing from the funds);
- Any deposits to the burial funds except interest payments which are allowed to remain in the fund;
- Any interest paid to me or my spouse directly from the burial fund; or
- Any purchase or gift of life insurance, burial contracts, burial insurance, etc., to pay for burial.

SIGNATURE (<i>Individual</i>):	DATE:
SIGNATURE (<i>Spouse</i>):	DATE:

08/15

Auxiliary Grant Program

STATEMENT OF VIRGINIA RESIDENCY AND INTENT TO REMAIN IN VIRGINIA

I, _____ have resided in Virginia for a
(Name of individual applying for AG)

minimum of 90 days and intend to remain in Virginia.

Signature of Individual/
Individual's Personal Representative: _____

Date: _____

Individual's Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____