

**SUCCESS DOCUMENTATION STANDARDS FOR ALL
MEDICAID PROGRAMS**

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SUCCESS DOCUMENTATION

Preface

A thorough interview is the cornerstone of accurate casework. However, SUCCESS fields do not always capture all the aspects of an effective interview. It is necessary to DOCUMENT to accurately address all required elements.

The following pages contain guidelines to standardize **basic** documentation in SUCCESS. Basic documentation is the minimal “generic documentation” that is required on all cases. There are, however, no “generic cases”. All cases are individual. Basic documentation addresses the elements shared by most cases. Additional documentation is usually required to address the unique aspects of each case.

General Rules

The purpose of documentation is to explain what SUCCESS cannot. When a SUCCESS field alone fully and clearly documents a situation, additional documentation is not required. It is not necessary to do “negative” documentation.

For example, there are multiple codes to document type of verification. “CS” for client statement, is usually a clear enough documentation of the source of verification. “TC” for telephone call would never, alone, be adequate for documentation.

Examples:

TC (telephone call)- requires documentation of the phone number called, the name of the person spoken to, the date of the contact and any other parts of the conversation that are relevant to the case.

OT (other)- requires documentation of the source of verification.

LE (letter)- requires documentation of who sent the letter.

Include additional documentation when required.

Identification

All documentation should start with the date of the action and include the case manager’s last name and first initial and caseload number. Revenue Maximization Units should indicate the unit you work for (Rev Max Region V, Rev Max Intake Unit, etc.) A blank line should separate the documentation for each date.

Children in Placement Medicaid

Documentation standards that are applicable to all Medicaid Programs also apply to Children in Placement. While SUCCESS is not programmed for certain COAs for foster or adopted children, all information and standard documentation must be entered when a foster or adopted child is determined to be RSM eligible.

RevMax staff are responsible for following all Medicaid SUCCESS Standardized Documentation for all case actions or contacts for cases in county caseloads when assisting counties in removing a child. Include the date of the action, case manager's last name and first initial, case load number, contact number and reason for the action or change and the actual date of the child's removal from the home.

Documentation for case circumstances, placement episodes, AFDC relatedness criteria and budgeting, removal home circumstances, court orders, reimbursability, and COA determination are in REMA behind the FCAR screen. Reference the FCAR Screen documentation standards for specific information.

A child must be removed from all active or pending cases prior to being placed in RSM Medicaid by Revenue Maximization Regional Centers. If the child is included in pending related cases (Food Stamps, TANF, LIM, RSM, etc.), the county is responsible for removing the child from the case in order for the RevMax MES to register the foster care case on SUCCESS. When a county removes a child from an active or pending TANF, Food Stamp and/or Medicaid case, the county will use code 569 to remove the child and waive Medicaid Adverse Action for the child only to prevent a delay in processing the Foster Care and Medicaid application. Adverse Action is not waived for TANF or Food Stamp cases. The RevMax MES will assist county offices in removing children from active cases when coming into custody.

Manual Tracking, Relative Placement, Continuing Benefits

There are circumstances when a child in care has a IV-E eligibility determination and is tracked manually and not through SUCCESS.

Food Stamp Applications

A Food Stamp application that includes a foster or adopted child may be completed by a county without transferring the Medicaid case from a RevMax caseload. The RevMax case will have the child as HOH, the living arrangement coded as FC and is a child only case. The Food Stamp application may be registered by another county using standard procedures. The living arrangement code will be entered as FC and the MISC screen will have the child coded as "Y" at the Auto Reassign Override.

Adoption Assistance

If during registration screening it is discovered that an Adoption Assistance child is receiving Food Stamps, do not remove the child from the ongoing benefits case, but notify the county worker to code the child's living arrangement as FC and to code the child's

Children in Placement Medicaid (cont'd)

Auto Reassign Override as “Y”. RevMax will process the Adoption Assistance Medicaid application.

Relative Home Placement – Reference Section 2848 – Relative Care Placement

If a county DFCS requests closure of a foster or adopted child’s case in order to process a relative’s pending application for TANF and/or Family Medicaid that will include the foster or adopted child in the AU/BG, MES will complete a CMD on the existing child’s case. The MES will code and document SUCCESS with the details of the change in placement, the outcome of the CMD determination and reimbursability. The case will then be transferred in SUCCESS to the county requesting closure following standard transfer procedures.

DFCS Relieved of Legal custody - Reference Section 2848 – Relative Care Placement

When a county requests closure of a foster or adopted child’s through Form 227, the RevMax MES will complete a CMD on the existing child’s case. The MES will code and document SUCCESS with the details of the change in custody, the change in placement, the new address of the child, outcome of the CMD determination and reimbursability. The case will then be transferred in SUCCESS to the resident county following standard transfer procedures. A “transfer” case record will be created and sent to the county.

Minor Parent Foster Child

A foster child has their child living with him/her in placement and assistance is requested for the minor parent’s child. If the child is not in DFCS custody, the minor parent’s child is not considered a foster child. The minor parent or the agency may apply for LIM, Newborn or RSM Medicaid for the child. It is preferable for the child to be F15, Newborn Medicaid, if all eligibility criteria for this COA are met. Reference 2162-Low Income Medicaid, Section 2174-Newborn Medicaid and Section 2182-RSM Child for eligibility criteria. Reference Section 2850- Special Considerations for procedures.

If the minor parent’s child is approved for any COA, the case is a child only case and the minor parent must be included in the child’s case as a Non Member (NM) in SUCCESS. The minor parent’s child’s case is retained in the same Rev Max caseload as the minor parent foster child. These procedures must be followed to prevent SUCCESS from pulling the minor parent foster child’s case into a county caseload with their child.

If the minor parent and his/her child are in an existing active Medicaid case when the minor parent comes into care, code the minor parent as a Non Member in the existing case and transfer to the Rev Max caseload. Complete the IV-E and Medicaid determination for the minor parent foster child per policy and procedures as a child only case.

Narrative Screen

The NARR screen should be documented for all case actions (application, review or change) and indicate what action is occurring. The documentation should include type of contact and/or action being taken. For all interviews, the documentation on NARR should reflect the initial conversation that the case manager conducts with the A/R prior to starting the interview on SUCCESS. Document the name of the person spoken to and that s/he is the best source of information. Document whether face to face, alternate or telephone interview is being completed. Document that A/R or authorized representative was mailed HIPAA form and/or EMA notification form if form was not completed at interview and is not in case record. Document date that a Form 315 was given or mailed for all LO1 cases and WO1 cases over age 55. If a SUCCESS letter template has been used, document the date letter was written, type of letter template (ex. M400), Load ID and name of the worker using the letter template. For Medically Needy, document actions taken and any pertinent information entered on SDME screen. Document validity of QITs, when sent to DCH Legal, when returned & outcome, if applicable. For Supervisory reviews document Supervisor’s name, date reviewed, and accuracy of AU, either “No corrections needed” or “Corrections due by mm/dd/yy”.

ADDR									
CHANGE		HOUSEHOLD ADDRESSES - ADDR					ADDR 01		
Month 11 02		10 19 01							
CO	LO	Load ID	Client ID		Prev CO/LO				
HOH	F	Name	L Name		Suf				
Auth Rep	Prim Lang	Voter Reg	Visually Impaired	Hearing Impaired	Public Hsng/ Rent Subsidy	Serial Number	Census Tract		
Y	E	N	N	N					
Residential Address									
Address Line 1					Line 2				
Street	Number	Dir	Name	Type	City	Dir	Apt		
City		ST	GA	Zip	Phone				
Mailing Address Del									
Address Line 1					Line 2				
Street	Number	Dir	Name	Type	City	Dir	Apt		
City		ST	GA	Zip	Previous Addresses in last 2 years N				
Message									
15-lett				21-narr		23-alau		24-del	

Document:

Questionable mailing address
 Directions to A/R home, if needed

AREP			
CHANGE	AUTHORIZED REPRESENTATIVE - AREP	AREP	A
Month 11 02	11 05 99		01
HOH Name		Client ID	
Rep Type R1	Relationship OR	Del	
F Name	L Name		
Address Line 1		Line 2 / Apt	
City	ST GA	Zip	Phone
Rep Type	Relationship	Del	
F Name	MI	L Name	
Address Line 1		Line 2 / Apt	
City	ST	Zip	Phone
Rep Type	Relationship	Del	
F Name	MI	L Name	
Address Line 1		Line 2 / Apt	
City	ST	Zip	Phone
			More
Message			
			24-del

Document circumstances related to A/R choice of:

Authorized representative (responsible person) for ABD and why (if not included on NARR screen)

For Children in Placement Document:

For Adoption Assistance children, complete AREP screen for adoptive parents. For children who move from an approved foster home placement to a relative placement, and custody is removed from DFCS, complete the AREP screen for new relative care placement. Document the relative's name, relationship and address. Details of the move from DFCS custody to a Relative Care Option are documented on REMA behind the FCAR screen.

TMAI				
INQUIRY Month 09 05	TMA INCOME - TMAI			TMAI
HOH Name AU ID	Client ID			
Date QRF Received	QRF Status Code	QRF Good Cause	Unemployed Good Cause	RSN QRF Incomplete
07 05 05	C			
QRF Months	Gross Inc	V	Dep Care	V
06 05	675.68	CS	0.01	CS
05 05	742.65	CS	0.01	CS
04 05	757.59	CS	0.01	CS
 Message				

Document:

How QRF information was received if QRF was not returned
 If QRF was received late or incomplete

STAT											
CHANGE		ASSISTANCE STATUS - STAT						STAT A			
Month 11 02		11 05 99						01			
AU ID	Prog MA	Prog Type A	Prev ABD	Type B	Med COA	L01	Claim N				
CO	LO	Load ID	Conversion Date								
AU	AU Status	AU Stat	Appl	Begin	Pd Thru	---Penalty---	Appeal				
Stat	Reasons	Date	Date	Date	Date	Type	End Date	Ind			
A		120197	112497	112597							

First	Last	Rel V	Mand Finl	--Stat--	Rsn	Appl	Begin	Pd Thru	Penalty		
Name	Name	Incl	Resp	Date	Date	Date	Date	Date	T	Date	
		SE	OT	N	RE	A	120197	112497	112597		
Message											
		20-rmen	22-alau(arch)	23-alau(curr)							

For all Medicaid programs Document:

Name, age, relationship of non-AU members and why they are not included in AU
 Unusual and/or financial responsibilities (example: step-parent with a mutual child)

Denials/closures codes entered by EW

Changes in AU (additions and deletion of AU members)

Circumstances and outcome of completing a CMD

Dual eligibility for more than one COA

Trace the relationship of the non-parent grantee relative to the children in the AU

If A/R over CAP, document if QIT is in place and effective date.

If coverage for retroactive months was requested then list what months and the eligibility determination for each of the months. If another AU ID number was used to process the prior months, cross reference this AU ID.

Note:

At application or review it is never acceptable to document:

“client states no change” or “client states no change in AU composition”

“Best Practice”: Document any referrals done on closed/denied cases.

DEM1									
CHANGE	CLIENT DEMOGRAPHIC 1 - DEM1							DEM1 01	
Month 11 02	A574 10 19 01								
Client Name				Suf	Client ID				
Alt Name	SSA/SSN Appl For	SSN Appl Date	SSN1	V	More SSNs	DOB (MMDDYYYY)	V	Sex	Race Eth
								M	B N
GA Res Y	Marital Status	Living Arrngmt	RSM Ad/Ch	Min /LA	Par Boarder Num Meals	Amt Paid for Meals	-- Family Planning Referral	-- Date	
	W		A						
Concurr Out of St CA	SSI FS	Depriv N	V MA	Prenatal Care Code	----- Term/Due Date	Pregnant Term/Due Exp	----- V	FTC Num V	Code I
N	N	N	I						
Message									
15-lett			16-crs			23-alau			

For Family Medicaid Document:

- Details of any enumeration penalty imposed
- Details of deprivation
- Any unusual circumstances about Georgia Residency
- How pregnancy was verified
- If pregnancy was terminated for a reason other than a live birth
- Code deprivation field correctly for CSE referral
- Form 138 was signed at interview or mailed to A/R (if required)

For ABD Medicaid Document:

- Previous Marriages
- SSI ineligibility
- Any unusual circumstances about Georgia Residency
- Reason for the Living Arrangement code entered; at reviews document that A/R remains in same LA or why it has changed

For Children in Placement Document:

- If an incorrect deprivation code is entered, document reason and correct deprivation.
- Details of deprivation are documented in REMA behind the FCAR screen.

DEM2											
CHANGE	CLIENT DEMOGRAPHIC 2 - DEM2						DEM2 01				
Month 11 08	A574 10 19 08										
Client Name						Client ID					
Citiz V	Orig	ID	Student V	High Grade V	Striker	---	Immunization	--	Law	-Health Chk	-
Cert	Stat		Completed	Stat	Curr	GCse	Due Dt	Brkr	Ref	Date	
C	BC	Y	AF	FT	CS					N	
TPL	TPL	V	-----	Medicare	-----	-----	Disability / Incapacity	-----			
Coop	Entitlmt	Claim Num	Disab	Approval	Begin Date	End Date	Type	Source	(MM YYYY)	(MM YYYY)	
N	C	CS	Y								
Joint	Vet	Military	Death	TANF Cap	Parent	-----	TANF Cap	Child	----		
SSI/FS	Stat	Serv Num	Date	Ctr	End Date	Parnt ID	Rcv Mo	Cncpt	GCse		
N	N										
Non-Custodial Parent?			V								
Message											
15-lett						22-tpl 23-alau					

For all Medicaid programs Document:

Details of disability/incapacity codes

Details, resolution of Death Match interface

Citizenship verification or Alien status if A/R is not a citizen. The type of evidence used to verify citizenship should be documented if not fully explained by the valid value. If receipt of Medicare or SSI is used to verify citizenship, this should be clearly documented. If citizenship is not verified by a document from the first tier, what was used for identity needs to be documented if not fully explained by the valid value. This should be done for each AU member.

Declaration of Citizenship is in record. Declaration of Citizenship can be addressed on DEM2 01 for ALL AU members.

Availability of TPL (TPL1 screen should not be used)

What form was signed for assignment of TPL. If A/R has TPL or there has been a change, document date form 285 sent to Health Management Systems, Inc.

Document that trusts and QITs are sent to DCH

Details of non-cooperation for TPL, if applicable

HIPP referral if applicable

Form DMA-327 sent to DCH upon death of recipient in L01 or W01

Health Check Program Referral (except for ABD COAs) TPL/Health Check can be addressed on DEM2 01 for ALL AU members.

ALAS									
CHANGE	ALIENS AND STUDENTS - ALAS					ALAS 01			
Month 11 02	10 19 01								
Client Name					Client ID				
Permanent									
Citiz	Elig V	Doc	Spons	Country	Entry Date	INS	--	Emergency Med	---
Stat	Type	Alien	of Origin	(MM YYYY)	Number	Ind	Beg Dt	End Dt	
C									
INS Auth To Work					Refugee Resettlement Agency				
Student Educ	School Name	Dep Care	Grad Date	Meals	20 Hr/Wk				
Status Level		Respon	(MM YY)	Provided	Work Rqmt				
NO									
School Attend Cd									
Message									
15-lett									

For all Medicaid programs document:

The 40 qualifying quarters for aliens
 Details of form 526 for EMA

For Children in Placement Document:

Alien status if applicable and all known school information

INST													
CHANGE	INSTITUTION - INST										INST 01		
Month 11 02	05 03 02										01		
Client Name	Client ID												
D Inst	Prov	Admission	Discharge	NH	LOC	V	Payment	--	Payment	--			
Type	ID	Date	Date	Perdiem	Auth		Auth Date	Term	DT	Rsn			
NH		08 15 98		106.00	I	DM	05 01 01	05	01	03	L		
Diversion	Dep/Family	Divert	Pat Liab	Inc	Incurr	MedExp	Inc	-	Medicare	-			
Amount	V	Num	Gross	Inc	V	Amount	V	Amount	V	Prot	Prem	Amt	V
Extra	-	HCB	Waiver	-	Deem	Wvr	DMA	Spcl	Length/	V	ICD-9	Recon	
Hardship	Type	Slot	Date	Cost	Eff	Wvr	Code	Stay	Met		Ind		
								Y	NH	25001	N		
												More Institutions	
Message													
	15-lett 16-pmen						24-del						

For ABD Medicaid Document:

- Level of Care: changes, date packet sent to GMCF & returned, reason if LOC is denied
- Limited Stay extensions
- Changes in institutional status (such as a change to Hospice COA)
- Residence prior to admission and upon discharge for protection of income determinations
- IMEs and verification source
- Diversion, if applicable
- Differences between admission date and payment date
- Reason for reconciliation and months affected
- Any periods not covered by DMA-6, Communicator or other LOC instrument
- Reason for use of Pat Liab Amount field; explain how the amount entered was obtained
- Hospital stays and how verified
- Explain reason for protection of income
- Circumstances behind reconciliation

APID														
CHANGE	ABSENT PARENT IDENTIFICATION - APID										APID	A		
Month 11 02											01			
HOH Name											Del AP	AP Returned Home		
AP Name											Suf			
SSN	Seq Num													
Dep	First	Last	Legal	Pat	Dep	First	Last	Legal	Pat	Dep	First	Last	Legal	Pat
Name	Name	Rel	Type		Name	Name	Rel	Type		Name	Name	Rel	Type	
IV-D	---	Good Cause	Claim	---	Referral	130 Form	UCB	Other	Income					
Coop	Ind	Rsn	Stat	Date	Date	Date	Ind	Types						
Union/Local														
Message														
	15-lett	20-next ap	23-alau	24-del										

For Family Medicaid Document:

Non-cooperation with CSS
 Good cause for failure to cooperate
 Changes and discrepancies in A/P information and dates any email Form 713 is sent to CSS
 If system Form 130 is sent, document date and worker load number
 If A/P unknown, explain
 If A/P has health insurance for the child(ren) and no CSS referral is made, enter "NOT APPLICABLE" for A/P name and document details

For Children in Placement Document:

Deprivation code must be entered to display the five (5) APID screens required to interface with the \$TARS child support system.
 Document all known information.

APAD				
ABSENT PARENT ADDRESS - APAD			APAD	A
Month	11	02	01	
HOH Name			Client ID	
AP Name		SSN		
Curr Addr Line 1		Line 2		
City	ST	Zip	Phone	
Date at Address				
Prev Addr Line 1		Line 2		
City	ST	Zip	Phone	
Date at Address				
AP's Father			Delete	
Street	City		ST Zip	
AP's Mother			Delete	
Maiden				
Street	City		ST Zip	
Message				
	15-lett	20-next ap		24-del

For Family Medicaid Programs Document:
 Changes and date email Form 713 sent to CSS

For Children in Placement Medicaid Document:
 All known information

APDE

Month 11 02 ABSENT PARENT DEMOGRAPHIC - APDE APDE A 01

HOH Name Client ID
AP Name SSN

----- Marital Information ----- Rel HOH Drvr Lic License Plate
Stat Date City ST To AP ST ST Number
N

DOB Approx ---- Birth Place ---- Sex Race Hgt Hair Eye Wgt
(MMDDYYYY) Age City ST Inches Color Color Lbs

----- Military Information -----
Stat ID Num Branch Entry Dt Exit Dt Allotment Pay Allotment Recip

----- Incarceration Information -----
Cd Release Dt Sentence Lgth Min Confine Institution
Yr Mo Yr Mo

Message

For Family Medicaid Programs Document:
Changes and date email Form 713 sent to CSS

For Children in Placement Medicaid Document:
All known information

APEM				
ABSENT PARENT EMPLOYMENT - APEM			APEM	A
Month	11	02	01	
HOH Name			Client ID	
AP Name		SSN		
Primary Employer Name		Delete	Occupation	
Address Line 1		Empl Date (MM YY)	Line 2	
City		ST	Zip	Phone
Secondary Employer Name		Delete	Occupation	
Address Line 1		Empl Date (MM YY)	Line 2	
City		ST	Zip	Phone
Former Employer Name		Delete	Occupation	
Address Line 1		Empl Date (MM YY)	Line 2	
City		ST	Zip	Phone
Message				
	15-lett	20-next ap		24-del

For Family Medicaid Programs Document:

Changes and date email Form 713 sent to CSS

For Children in Placement Document:

All known information

APCO

ABSENT PARENT COURT ORDER - APCO APCO A
Month 11 02 01

HOH Name Client ID
AP Name SSN

Order Support Support Freq Payee Docket
Date Obligation Arrears Code Number

Paying Date of Last Pymnt Agency Receiving Payment
Support Last Pymnt Amount

15-lett 20-next ap

For Family Medicaid Programs Document:

Changes and date email Form 713 sent to CSS

For Children in Placement Document:

All known information concerning court ordered child support and/or insurance coverage
Copy of insurance card in file

FCAR		
CHANGE Month 11 02	FOSTER CARE - FCAR	FCAR 01
Client Name		Client ID
Date Petition Filed		Type of Placement
Date of Court Order/Placement Agreement		
Order Wording/Valid Agreement Indicator		Elig/AFDC When Removed
Name of Agency/Individual with Placement Responsibility		
Date Court Order/Placement Expires		
Name of Foster Parent/Placement Source		
Message	15-lett	

For all Medicaid Programs Document:

Details of home from which child was removed and how the child's eligibility for IV-E eligibility was determined

Reimbursability, status of foster home, court orders and required language, deprivation and child's income

Identify any months of non-reimbursability and explain

Document Chafee Independence Program new application details for verification of foster care status, Third Party Resources, citizenship/identity, residency, and age..

For Children in Placement Document:

Initial removal and placement, all additional court orders, placement episodes, changes

The case narrative for all children in placement is REMA behind the FCAR screen. This includes initial placement and application, reviews, subsequent placement episodes and/or changes. All narratives should start with the date of the action, the type of action and include the case manager's last name, first initial and caseload number, Revenue Maximization location and telephone number. A blank line should separate the narrative for each date.

REMA should be a chronological narrative of the case's history.

Initial placement information should include:

- Date entered into custody
- Date of application and SOP
- SSCM's name, county and telephone number
- Initial court order type, date and required language, date order received from SSCM
- "removal from" and "living with" specified relative, removal home information
- Briefly address the AFDC relatedness criteria for age, deprivation, financial need and citizenship/alienage for the eligibility month and address OCSS referral requirements. Alien status verified? Reference Section 2215.
- Current placement and reimbursability
- COA determination and/or CMD
- Follow-ups needed with type and date, any specific information that was unusual and needed for the case. An ALERT will be used as a follow-up to complete information needed.
- 962 requests, document who requested, 962 sent to, date sent, and address
- Date Form 529 sent to county and accounting
- Need for prior months MAO, gaps in Medicaid coverage reinstated and any action taken

Chafee Independence Program Medicaid:

Verification of foster care status. If contacting a state other than Georgia for verification of foster care status and no written verification is provided, document state, agency, contact name and number, details of verification of foster care status for month of 18th birthday. Screen print this information for case record documentation

Verification of TPR.

Document the CMD process for existing foster care youth.

All subsequent narratives should include type of action, collateral contact and all information relevant to the action.

RES1

CHANGE	RESOURCES 1 - RES1	RES1 01
Month 11 02	10 19 01	01

Client Name	Client ID
-------------	-----------

Do you have any of the following: cash, money loaned out, checking, savings, credit union, CD's, stocks, bonds, or secured notes?

Del Type	Amount	V	Acct Num	Institution Name
PF	75.61	OT		

Do you have any of the following: life insurance, pre-paid burial contracts, real estate, or cemetery lots?

Del Type	Face Amt	Cash Amt	V	Policy Num	Company Name
----------	----------	----------	---	------------	--------------

More

Message

15-lett

23-alau 24-del

For all Medicaid Programs Document:

Conversion or disposition of resources at review or interim change, including spousal impoverishment

Explain any unusual activity involving resources and countable value if amount is not readily apparent

For ABD Medicaid Program Document:

Dates of letters, bank statements, etc. used as verification

Potential inheritances

Disposition of previously owned bank accounts or other resources, and potential jointly owned resources at review or interim change

Burial fund exclusions (life insurance, burial contracts, burial funds)

Explain financial instrument used to fund QIT

For Promissory Notes, Loans and Property Agreements explain how the resource amount was calculated

RES2											
CHANGE Month 11 02	RESOURCES 2 - RES2	RES2 01 01									
Client Name	Client ID										
Do you have any of the following: truck, motorcycle, tractor, farm equipment, licensed/unlicensed vehicle(s), boat, camper, income producing vehicle?											
Del Type	Use	FMV	V	Encumb	V	Yr	Make	Mod	Lic Num	Registration	
MA/AF FS											
VIN											
Do you have any of the following: vacation home, real estate, or rental prop?											
Address	City	ST	Zip								
Del	Use	FMV	V	Encumb	V	Try	Annl Rate	V	Age Life	to Sell Ret Amt Est Own	
Message	More										
15-lett				23-alau				24-del			

For all Medicaid programs Document:

- Good faith efforts to sell
- Bankruptcy
- Conversion or disposition of resources at review or interim change, including spousal impoverishment
- Vehicle use if use code is not self explanatory
- Joint ownership

For ABD Medicaid programs Document:

- Liens
- Rebuttal process
- Completion of property search the results and any discrepancies
- If more than one vehicle, vehicle excluded and reason
- Life estate
- Disposition of previously owned property
- All real property other than homeplace

RES3		
CHANGE Month 11 02	RESOURCES 3 - RES3	RES3 01 01
Client Name	Client ID	
Do you have any of the following: safety deposit box, business holdings, non-home consumption produce, livestock, or other valuables?		
----- Other Property -----		
Del Type	FMV V	Encumb V Annl Rate V Return
Message		More
15-lett		24-del

For all Medicaid programs Document:

Details of any resource listed on this screen

Conversion or disposition of resources at review or interim change, including spousal impoverishment

For ABD Medicaid programs Document:

For FBR cases, burial space exclusion if not evident from verification in record

Any amount entered as "OC" due to burial exclusion

TRAN									
CHANGE		TRANSFER OF RESOURCES - TRAN					TRAN 01		
Month 11 02							01		
Client Name					Client ID				
Del	Transf	Discovery	Transferee	Resource	FMV	V	Amt	V	
Ind	Date	Date	R'Ship	Type			Rec'd		
	(MM YY)	(MM YY)							
Reason for	Undue Hardship	1st Mth							
Transfer	Ind Rsn	NH/Wvr MA							
		(MM YY)							
Message							More		
15-lett					24-del				

For ABD Medicaid programs Document:

Details of any transfer and verification used or A/R's statement that no transfers have been made

Details of any recalculation of penalty and verification used

For Promissory Notes, Loans, Property Agreements that result in a transfer penalty explain how the penalty amount was calculated.

ERN2									
EARNED INCOME 2 - ERN2					ERN2 01				
Month 11 02					01				
Client Name					Client ID				
Employer Name									
Avg Hrs		Freq		Day Week Pd			Extra Pay		
Del									
Amt 1 V		Amt 2 V		Amt 3 V		Amt 4 V		Extra V	
----- Work Expenses -----									
Type		Amount		Freq V		Type		Amount Freq V	
Message									
More Jobs									
15-lett		16-evnc		23-alau		24-del			

For all Medicaid programs Document:

Hourly pay rate

Tips, if not included in gross pay on the pay stubs

Reason any pay period is NOT considered representative pay

If actual income used in budgeting explain

If verification is required but is not in case record, how was information verified

For example: YTD, TC

IF EVNC is not used, explain calculation and frequency of pay

EVNC

CHANGE EARNED VARIABLE INCOME CALCULATION - EVNC EVNC 01
Month 11 02

Client Name

Client ID

Del	Avg Hours	Freq	Day Week Pd	Extra Pay
-----	-----------	------	-------------	-----------

PP End Date MM DD YY	Pd/Rcvd Date	Amount	V	Repres
-------------------------	--------------	--------	---	--------

Message

24-del

All documentation should be on the ERN2 screen

DEAL					
CHANGE	DEEM/ALLOCATE - DEAL			DEAL 01	
Month 11 02					
Client Name					Client ID
----- Deemor Budget -----			----- CS Paid Outside Home -----		
Num IRS Dep	Alimony V	Other Exp V	Del Oblig Amt V	Paid Amt V	
----- ABD Allocation -----					
Inelig		Inelig			
Del Ind	Amount V	Del Ind	Amount V	Number Of ABD Child Appl Recip	
----- Alien Sponsor -----			----- AF Allocation -----		
Amt Actually Contributed/V			Client ID		
Number of Other Spons Aliens			Who can		
Number of Other FS Recips Spons			Allocate to me		
Message					
15-lett			24-del		

For all Medicaid programs Document:

Alien sponsor's name and address

For Family Medicaid programs Document:

For deemor budgets: Names of persons counted as IRS dependents

For allocation, who can income be allocated to

For ABD Medicaid programs Document:

Ineligible children and type of income

CARE									
CHANGE	DEPENDENT CARE EXPENSES - CARE						CARE 01		
Month 11 02	07 23 02						01		
Client Name					Client ID				
Provider					Phone				
Address	City			ST GA		Zip			
More providers									
Del	Extra Dependent Expense			Day of Week Pd		Rsn EM			
Depname	Und2	Freq	Date Pd	Amt	Date Pd	Amt	Date Pd	Extra	V
JONAH	N	BW	04 04 02	50.00					
PR									
More Dependents For This Provider									
Message									
15-lett					24-del				

For Family Medicaid programs Document:

If AU is eligible for the dependent care deduction and no expense is reported, document childcare arrangements

If subsidized care is being provided

Each child for whom care is being paid should be listed individually on the CARE screen

UINC						
CHANGE	UNEARNED INCOME - UINC			UINC 01		
Month 11 02				01		
Client Name			Client ID			
Do you have any of the following: RSDI, alimony, direct child support, contributions, VA, workers compensation, unemployment, sick/disability benefits, pension, railroad retirement, any other retirement, rent, interest, annuities, dividends, educational income, or striker benefits?						
Type	Del	Freq	Claim Number	Ded	Ded Amt	Extra Pay
Date Rcvd	Amount	V	Date Rcvd	Amount	V	Date Rcvd
Client Potentially Elig For Other Benefits?						More
Appl Type	Stat	Date	Appl Type	Stat	Date	
Message						
15-lett		16-uvnc		23-alau		24-del

For all Medicaid programs Document:

- Date payments will begin and/or terminate
- The source and expected duration of any contributions
- Reason net instead of gross income is used
- Calculation of monthly interest payment or child support payments, if needed
- Financial aid for students
- Reason for any changes to the auto update
- If A/R is receiving RSDI on someone else’s account, the name and relationship,
- The reason any fluctuating income is not considered representative
- Details of application for any other benefits; explanation for not requiring application when potentially eligible.
- The results of clearinghouse (UCB/SDX/BENDEX) automatic matches and the resolution of any discrepancies

For ABD Medicaid programs Document:

- Dates of award letters, bank statements, etc
- Reason for any deductions or exclusions, including for QITs
- Potential income based on past work history, spouse, etc
- If no income, document potential SSI eligibility
- Document receipt of or potential benefits for VA, when application filed with VA, etc.
- For Promissory Notes, Loans, and Property Agreements document any resulting countable income and how it was calculated.

For Children in Placement:

See Appendix K, work around for receipt of SSI

PLAW		
CHANGE Month 11 02	PUBLIC LAW DISREGARD - PLAW	PLAW 01
Client Name		Client ID
Client RSDI Claim Number		
Previous SSI/MSS/AABD		
Concurrent & Correct SSI/MSS/AABD		
Date of SSI/MSS/AABD Inelig		
Reason for SSI/MSS/AABD Inelig		
RSDI Initial/Increase Entitlement		V
COLA Disregard Amt		V
Message		
15-lett		

For ABD Medicaid programs Document:

How determination was made and why person is eligible
Yearly COLA

ISM1																	
CHANGE	INKIND SUPPORT & MAINTENANCE 1 - ISM1						ISM1	A									
Month 11 02																	
HOH Name					AU ID												
HH Expense Type			Amt		V		HH Expense Type			Amt		V					
Rent							Mortgage										
Electric							Taxes										
Gas							Water										
Sewer							Garbage										
Heating Fuel							Insurance										
Food							Other										
Clients Contrib				Outside Contrib				Inside Contrib									
Type		Amt		V		Type		Amt		V		Type		Amt		V	
Food						Food						Food					
Shelter						Shelter						Shelter					
Other												Other					
Number		Sharing		Household		Ownership		Parent/									
Food		Shelter		Situation		Rent Lib		Child									
Message										15-lett							

For ABD Medicaid programs Document:

Details of determination of ISM, including manual budget or “see Form 969 in case record”

MISC															
CHANGE	AU NON-FINANCIAL MISCELLANEOUS - MISC										MISC	A			
Month 11 02															
HOH Name								Client ID							
AU ID								Prog MA							
Pre	Pre	AU	ATP	ATP	QRF	QRF	Pre-	Calc	Trial	Pro	Exp	SLAM	-Extended	MA-	
Issn	EBT	Issn	Prnt	Cyc	Status	Ctr	sump	Elig	HH	Ovr	Svc	Cd	Start	Dt	COA
Card		Mode	Cnty	Num	Code		Elig	Ind	Ind					Cor	
----- Review ----				Auto	-----Lump Sum Remainder-----				Delay	QMB	RSM				
Compl	Mand	Last	Reasgn	Amount	100%	133%	185%	Rsn	Ovr	Elig					
Std		Type	Ovr								Ovr				
			N												
Sched Interview								QC Penalty End Date							
Del	Unit Number				Inquiry Date				Load ID						
Next Review S				Appt Date				Appt Type							
Appt Begin Time (HH:MM) :															
Appt End Time (HH:MM) :															
L Name/Appt Remarks								Appt Letter Print Location L							
Message															
13-note 14-schd 15-lett					20-schs				23-alau						

For all Medicaid programs Document:

Why the case is over the SOP (Valid Value is never sufficient)

For Family Medicaid programs Document:

How the first month of TMA was established

For ABD Medicaid programs Document:

QMB override reason