RECORD OF RECEIPT OF MANUAL TRANSMITTALS

ECONOMIC SUPPORT SERVICES POLICY MANUAL
MEDICAID PROGRAM
VOLUME II

File this form in front of the Medicaid volume.

Make changes specified in the transmittal.

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02	3-18-02	BP			
03	7-1-02	BP			

ECONOMIC SUPPORT SERVICES

MEDICAL ASSISTANCE PROGRAM (MEDICAID)

VOLUME II

The purpose of the Medical Assistance Program is to promote improved health care for low-income families, children, pregnant women, and persons that are aged, blind or disabled.

The Medical Assistance Program is authorized by Title XIX of the Social Security Act, Title 42 of the Code of Federal Regulations. The Medicaid program is administered by the Center for Medicare and Medicaid Services of the United States Department of Health and Human Services (DHHS).

The Department of Community Health Services (DCH), by virtue of O.C.B.A. 549-4-142, is the single agency for the State of Georgia responsible for the administration of the Medical Assistance Program.

The Department of Human Resources (DHR) is responsible for administering certain aspects of the Medical Assistance Program in Georgia per contract with DCH. There are currently two contracts between DCH and DHR involving Medical Assistance. The first contract specifies Administrative and Support Services and the other specifically addresses Eligibility Expansion Caseworkers (the RSM Project). The local Departments of Family and Children Services are responsible for Eligibility Determination and other related support services.

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2000 - GENERAL PROGRAM OVERVIEW

POLICY STATEMENT	The General Program Chapter contains policy on topics that are related to or associated with the Medicaid Program.
BASIC CONSIDERATIONS	The following topics, identified in bold, are included in this chapter: • **Computer Matches** provides an overview of matches with the files of various governmental agencies including IEVS, IRS/BEERS, Clearinghouse and SSN Validation. • The section on **Confidentiality** provides policy based on laws that govern the AU's right to keep knowledge of case information limited to certain individuals. • **Mandated Reporting** explains the requirement and process of agency employees to report suspected child abuse. • **Americans with Disabilities Act (ADA)** gives policy guidance for providing reasonable access to programs for persons with disabilities.

2001 - COMPUTER MATCHES OVERVIEW

POLICY STATEMENT	Applicants and recipients whose resources and income are used to determine eligibility are matched with the files of various governmental agencies.
BASIC CONSIDERATIONS	The applicant's and recipient's (A/R's) primary social security numbers (SSN) are matched with SSNs contained in other governmental agency files. The information associated with the SSNs is compared. Discrepancies are identified for follow-up and investigation. Computer matches through the use of the A/R's SSN are designed to detect income, resources, and to provide other pertinent information required to establish eligibility and benefit levels. Information obtained from the computer matches is used for the following purposes: • to verify eligibility of A/Rs, • to verify the proper amount of benefits, • to determine whether recipients are receiving the benefits to which they are entitled, • to obtain information to use to conduct criminal or civil prosecutions based on receipt of benefits to which recipients are not entitled. Computer matches are accessed via system terminals or through personal computers connected to the system. Users must have a valid password which is obtained from the State Office. Unlawful access is prohibited. A record of all inquires by password is kept and monitored by the system.

2002 - INCOME AND ELIGIBILITY VERIFICATION SYSTEM

POLICY STATEMENT

The Income and Eligibility Verification System (IEVS) is a federally operated system through which agencies request data, wage and benefit information on program applicants and recipients from other state and federal agencies.

BASIC CONSIDERATIONS

IEVS computer matches are performed by SUCCESS with the following files from other agencies:

- SSA Beneficiary Earnings Exchange Record (BEER)
- United States Internal Revenue Service (IRS)
- Interstate Files
- SSA Prisoner Verification Inquiry
- SSA Death Verification Inquiry
- SSA Bendex
- SDX

A wage and benefit match is completed to compare the information in SUCCESS and other computer files. If a match is found and the information in a computer file differs from the information in SUCCESS, a system-generated alert is sent to inform the worker of the discrepancy. The worker takes action to resolve the discrepancy and documents those actions in the A/R's case record. Refer to SUCCESS Documentation Standards for documentation requirements.

The SSA Prisoner Verification Inquiry and SSA Death Verification Inquiry match the files of the Social Security Administration with SUCCESS files to determine if A/Rs are incarcerated or deceased.

IRS and BEERS information are subject to special security considerations. Refer to Section 2003, IRS/BEERS Security.

PROCEDURES

Follow the procedures below to process data received from the computer matches.

Processing Match Data

Use information received from the matches to determine eligibility and benefit level.

Complete case actions to resolve discrepancies within 45 days of receipt of the information.

Completion of case actions may be postponed to the next review if the actions cannot be completed due to non-receipt of verification already requested from a collateral contact.

PROCEDURES (cont.)

Verification

Consider the following information as a lead and verify the income information when a match is received:

- RSDI benefits,

  NOTE: Verify gross RSDI income on Clearinghouse.

- DOL earned income matches
- IRS earned income and pension matches
- questionable IEVS information
- prisoner verification data.

Documentation

Record the following information:

- results of the case record screening
- the reason a discrepancy does not exist, if applicable
- date verification was requested and from whom verification was requested
- date action has been taken to correct ongoing benefits
- date of completion of the case action to resolve the discrepancy

2003 - INTERNAL REVENUE SERVICE (IRS) AND BENEFICIARY EARNINGS EXCHANGE RECORDS (BEERS) INFORMATION SECURITY

POLICY STATEMENT

DFCS is required to establish and maintain certain safeguards designed to prevent unauthorized use of the information and to protect the confidentiality of the information received from IRS and BEERS computer matches.

BASIC CONSIDERATIONS

As a condition of receiving IRS/BEERS information, DFCS is required to establish and maintain certain safeguards. Penalties for unauthorized disclosure of IRS/BEERS information are found in an email entitled Safeguard of IRS Data dated August 30,1999, and posted on the GO-Mail bulletin board SUCCESS/NOW.

The following security measures to ensure that information is secured in accordance with the federal laws must be taken in each county office:

- IRS/BEERS County Security Plan

  Each county department is to complete and submit the IRS/BEERS County Security Plan Form to:

  Economic Support Services Section
  Two Peachtree Street, NW Suite 21-205
  Atlanta, Georgia 30303
  ATTN: Doretha Watkins

  A copy of the completed plan must be maintained in the county for audit purposes.

- IRS/BEERS Training and User Access Agreement

  County Departments must provide IRS/BEERS training to staff who process or have access to contact with IRS/BEERS information. Following training, staff must sign the IRS/BEERS User Access Agreement Form. County departments must also provide annual IRS/BEERS refresher training as well as have the User Access Agreement Form signed no later than October 1st of each year. A log with the names of trainees must be completed at each training session.

  New employees must receive IRS/BEERS training and sign the User Access Agreement Form during county orientation prior to new worker training and having access to secured information. The names of new employees are to be added to the training log when orientation is completed. The Program and Administrative Section will reinforce security and confidentiality policies during new worker training.

BASIC CONSIDERATIONS (cont.)

Copies of training logs and completed access agreement forms are to be maintained in a central location for audit purposes. The original IRS/BEERS User Agreement Form is placed in the employee's personnel file.

Each county department will receive two videos entitled Safeguarding Federal Tax Information and Stop UNAX In Its Tracks. County departments will also receive Eligibility Systems County Letter 97-6, Security Destruction Procedures for IRS and BEERS, and DFCS Systems County letter #99-700, Internal Revenue Service Interface Safeguards and SUCCESS Procedures. Security Destruction Procedures for PARIS IRS and BEERS Materials. These materials are to be used to train staff.

The Secured Verification letter is to be sent to third parties such as financial institutions, employers or retirement boards, etc. Copies of the Secured Verification Letter are maintained in a two-barrier secure environment until the completed Secured Verification Letter is returned by the third party. When the completed form is returned, the copy is logged and shredded. The destruction of the copy of the Secured Verification Letter is logged in on Form 379. If the third party completes the Secured Verification Letter and returns it to the county department, the top portion of the form is logged and shredded. The bottom portion may be filed in the case record. If the third party returns the verification using a document other than the Secured Verification Letter, the other document is filed in the case file.

- SUCCESS remark and narrative screens may not be documented using verbiage, which indicates that information was received from IRS/BEERS. Case files may be documented to state that secured verification has been requested.

- All staff including Quality Control reviewers and fraud investigators who request verification are to adhere to the secured verification procedures.

- Mailing Secured Verification Letter

  Verification requests related to IRS/BEERS are to be safeguarded until transported to the mail carrier. Each county department is to develop procedures to ensure that the safeguards are in place. Include these procedures in your IRS/BEERS county security plan.

BASIC CONSIDERATIONS (cont.)

- The Information and Technology (IT) Section, Economic Support Services Section, Quality Assurance Section, and Program and Administration Section are involved in helping counties meet security objectives. The Quality Assurance Evaluation and Reporting Review is used to evaluate the security measures.

- Posters

  County Departments will also receive an UNAX (unauthorized access) poster to display in employee areas within the building.

- Limiting Access to IRS and BEERS Data

  Based on the RACF User ID, many DFACS personnel have access to IRS/BEERS data. Access should be limited primarily to caseworkers, unit supervisors, and at times, clerical staff and county directors. Only staff members who have a need-to–know should have access to these files. Restricting access to designated personnel minimizes the risk of improper disclosure. It is recognized that often it is not feasible to limit access to individuals who receive the information. It may be necessary to forward information to technical or clerical employees for processing, but no employee should be given greater access than is needed to perform his or her duties.

  If an employee will no longer have access to IRS/BEERS information, , complete Form 357, Request For SUCCESS Worker ID Form, to delete or change the RACF USER ID. In addition to the identifying information, complete Part V: Deletion. Check the box entitled Other Reason. Write in the blank next to the Other Reason box the statement, "restrict access to A&B and L&M on Omen. Check the appropriate boxes for former employees who have resigned, retired, changed duties, etc. The completed Form 357, is returned to:

  DHR Information and Technology
  Two Peachtree Street, 25th Floor
  Atlanta, Georgia 30303
  ATTN: Security Unit.

BASIC CONSIDERATIONS (cont.)

- Security Destruction of Information

  Refer to Eligibility Systems County Letter 97-6, Security Destruction Procedures for IRS and BEERS and DFCS systems county letter #99-700, "Internal Revenue Service Interface Safeguards and SUCCESS Procedures. Security Destruction Procedures for PARIS IRS and BEERS Materials." A copy of the Income Eligibility Verification System (IEVS) Print Log-In, Form 379 is attached to this county letter. County departments are to duplicate this form for future use. Logs that have been used are to be stored securely with other IRS/BEERS information.

- Record Keeping

  IRS/BEERS information such as copies of alerts, verification requests and destruction logs must be stored in a two- barrier security system. The two- barrier security system mandates that the information must be maintained in a locked file cabinet or container located in a locked room, if not occupied by personnel who are authorized to access the information. If authorized personnel leave the room for any reason, the room must be locked.

- Restricted Access Requirements

  No more than two or three employees are to have keys to the room and file. Landlords, maintenance personnel and non-DFCS security personnel cannot have access to the locked room. Key access will be addressed at each Evaluation and Reporting Review. Maintenance of the room is to be performed under the supervision of an agency employee.

- Case File Purge

  IRS/BEERS information may not be maintained in case files. IRS/BEERS information, which is currently maintained in case files, must be purged and placed in storage or destroyed, if appropriate. Until case files are purged, the county department must ensure that case files containing IRS/BEERS information is secured in a two-barrier security system.

  Case files are to be purged of printed copies of IRS/BEERS alerts verification requests and of verification resulting from IRS/BEERS systems alerts.

BASIC CONSIDERATIONS (cont.)

- IRS/BEERS SUCCESS Alerts

  SUCCESS alerts are addressed in DFCS Systems County Letter #99-700. If there are questions, contact the SUCCESS help desk. In addition to the IRS alerts provided in CL#99-700, BEERS Alert 229 indicates that a child has earnings. STAT Message #99-056 dated August 30, 1999 provides SUCCESS procedures for safeguarding data. The SUCCESS Manual, Section 6.1, pages 4-7 provides instructions for inquiry and updating income discrepancies.

- Secured Verification Letter and Documentation of Case File

  Federal law requires an Income and Eligibility Verification System (IEVS) for use in administering the programs. When IRS/BEERS file information is discrepant with the information in DFCS records, an alert is generated to provide information. Before this information may be used to terminate, deny or reduce benefits, a third party must verify the information. Until the form is distributed through DHR Central Supply, county departments are to duplicate it for future use. The Secured Verification Letter is to be exclusively used to verify IRS/BEERS information. It is to be manually completed and filed in a two-barrier security environment. **Do not use computer-generated letters to verify IRS/BEERS information.**

2004 – CLEARINGHOUSE

POLICY STATEMENT

Clearinghouse is an automatic on-line computer system through which wage and benefit information on applicants and recipients is matched with files in other state and federal agencies.

BASIC CONSIDERATIONS

Clearinghouse matches are performed with the following agencies and contain the following information:

- Department of Labor (DOL) Wage Files –
  the most recent five quarters of employment history by employer name, employer number, and amount of wages earned
- Department of Labor (DOL) Employer Address Files –
  the work location and/or the address of the accounting office
- Department of Labor (DOL) Unemployment Compensation Benefits (UCB) -
  the monthly UCB amounts for the most recent 13 months and a list of individual checks for the last ten weeks
- Department of Labor (DOL) Unemployment Compensation Benefits (UCB) Claimant Address File –
  the address of each UCB recipient
- Department of Labor (DOL) W-4 Employer Reporting System –
  the name and address of any new employer and the date of hire
- BENDEX –
  RSDI benefit information on individuals who are current or past recipients of public assistance.
- State Data Exchange (SDX) –
  SSI benefit information.

Clearinghouse files are accessed on any individual who is in active or pending status, is age 14 or older and who may affect eligibility for benefits such as the following:

- applicants
- recipients
- ineligible aliens
- sanctioned individuals

PROCEDURES

Clearinghouse is accessed on pending or active AU's at the following times:

- at registration or finalization of a new AU or reopening of an AU
- in the month prior to the review month, when the AU is selected for review
- if a primary SSN is changed
- adding a person to the AU at an interim change.

2005 - SSN VALIDATION

POLICY STATEMENT	The system interfaces with the files at the Social Security Administration (SSA) to verify the accuracy of the SSN of an AU member.
BASIC CONSIDERATIONS	All SSNs entered in the system will interface with SSA files.
PROCEDURES	

Use the following procedures to complete the validation requirements:

Chart 2005.1- SSN Validation

IF AN AU MEMBER'S SSN	THEN
is valid	the system will annotate the SSN with a FV (federally verified). No further action is required.
appears on the system generated enumeration or validation discrepancy lists **NOTE:** An alert is generated.	determine if the AU member's full name, DOB, and SSN matches information on the individual's official documents. Correct any information that is in error. Refer the A/R to SSA for corrective action if the SSA information is the source of the error.
matches with another SSN known in the system	determine which number on the system is correctly assigned. Correct any SSNs erroneously entered in the system OR refer the AU member to SSA for corrective action if multiple individuals are assigned the same SSN.
is validated by the system but differs from the verification (SSN card) obtained from the A/R	follow the steps under How to Change a Validated SSN in this section.

PROCEDURES (cont.)

How to Change a Validated SSN

Step 1 Gather the following case identifying information and report it in the order listed:

- worker's name
- worker's telephone number
- county, office, supervisor, load number
- AU number
- AU name
- AU member's name
- AU member's ID number

Step 2 Route the above information to the following address:

Information & Technology (IT)
Two Peachtree Street, NW
Room 25-205
Atlanta GA.30303
Attn: SSN Validation

OR

Send E-mail message with the above information to GO-Mail address:

HD.SUCCESS1

Step 3 Correct the SSN when IT provides notification that the validation code has been removed.

2010 - CONFIDENTIALITY

POLICY STATEMENT	Any information related to individual applicants and recipients of programs administered by DFCS is confidential and is governed by regulations, which specifically forbid the release of this information to unauthorized persons or agency representatives.
BASIC CONSIDERATIONS	All case record material is confidential, including the names and addresses of applicants and recipients, as well as the types and amount of benefits provided. Case record information may be released to the following: • the A/R • the authorized representative • an individual or agency if the A/R signs Form 5459, Authorization of Release of Information The following information may not be released to anyone, including the A/R: • medical or psychiatric information marked *confidential* if the information in the record could be harmful to the A/R • information provided by an individual who has requested confidentiality • confidential information regarding a pending criminal prosecution • information obtained from the IRS. Penalties for release of IRS information include: • a fine in any amount not exceeding $5,000 or imprisonment of not more than 5 years, or both, including costs of prosecution for felony disclosure, • dismissal from employment, • discharge from employment upon conviction for such offense, • civil action for damages against the taxpayer brought by that taxpayer in a district court of the United States. If the A/R requests any of the above information, refer the A/R to the source. **NOTE:** The county office may charge for photostatic copies of case record material.

PROCEDURES

Release the requested information pertinent to service delivery to the following agencies or their representatives without obtaining the A/R's permission:

- individuals directly connected with the administration of the DFCS, Child Support Program, Office of Investigation Services, Health and Human Services and SSA employees as necessary to assist in establishing or verifying eligibility benefits under Titles II and XVI of the Social Security Act
- individuals directly connected with other federal assistance programs and federally assisted state programs providing assistance on a means tested basis to low income individuals
- persons directly connected with the administration of the Income and Eligibility Verification System (IEVS)
- employees of the Comptroller General's Office of the United States for an audit examination.
- the current address of any fugitive felon or AU member who has knowledge of the fugitive felon's whereabouts may be given to a law enforcement officer if the name and social security number (SSN) of the felon is known by the officer.
- name(s) and address(es) only of participating AU's to persons directly connected with nutrition education,
- researchers authorized in writing by the agency,
- public officials who request information in writing and the request originated from an inquiry by the AU,
- emergency situations in which the County Director, Field Director, or Division Director judges that the release is necessary to prevent loss of or risk of life or health upon approval from the State Office. Notify A/R immediately of this release.

2015 - MANDATED REPORTING

POLICY STATEMENT

The Official Code Section 19-7-5 updated through the 2000 Session of the General Assembly states: The purpose of this code section is to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection. It is intended that the mandatory reporting of such cases will cause the protective services of the state to be brought to bear on the situation in an effort to prevent further abuses, to protect and enhance the welfare of these children, and to preserve family life whenever possible.

BASIC CONSIDERATIONS

Section One (1) of the above-stated law mandates that all DFCS employees are responsible for reporting suspected child abuse or neglect to Child Protective Services (CPS). The following is a list of what must be reported to CPS:

- observed signs of physical abuse on a child
- observed abusive action imposed on a child
- information about suspected abuse or neglect toward a child disclosed to you during an interview or conversation
- information about suspected abuse or neglect toward a child disclosed to you during a phone call. Refer this person to CPS Intake. Follow-up the conversation with a written referral to CPS Intake. Maintain a copy of the referral in the case record

If there is doubt as to whether or not a report should be made, make the report. CPS intake workers screen all reports and determine whether or not to open an investigation. If there is doubt, err on the side of the child's safety.

PROCEDURES

The following steps should be taken when making a CPS referral:

Step 1 Suspected acts of abuse or neglect toward a child are observed or discovered through conversation.

Step 2 If the behavior is being exhibited in the county office, arrange for the CPS intake worker to talk with the client. Follow up the request to CPS in writing. Make a copy of written referral for case record.

PROCEDURES (cont.)

Step 3 If CPS intake is not available or the client is not present, make a written referral to CPS and make a copy of the referral for the case record. Include the following information in the referral:

- child's name, age, gender, address and current location if different from the address
- parent/guardian's name, address, phone number
- reason for referral
- reporter's name, address, phone number and relationship to the child.

NOTE: The Reporter has the right to remain anonymous. Note that on the referral if this request is made.

2020 - AMERICANS WITH DISABILITIES ACT

POLICY STATEMENT	Persons with disabilities cannot be discriminated against, but must be provided with opportunities equal to persons without disabilities in accessing government programs, public services and employment.
BASIC CONSIDERATIONS	The Americans with Disabilities Act (ADA) gives civil rights protections to individuals with disabilities. These protections are similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. The ADA guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. In general, the ADA became effective on January 26, 1992. The Americans with Disabilities Act is intended to remove barriers that persons with disabilities may have to employment, public accommodations, public services, and telecommunications. It prohibits discrimination in all employment practices, including job application procedures, hiring, firing, advancement, compensation, training, and other terms, conditions, and privileges of employment, and to all employment-related activities. Title II of the ADA prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services of public entities. It applies to all State and local governments, their departments and agencies, and to any entities with which a government agency contracts for services. Unless the government can establish that a requirement is necessary for the provision of a service, program, or activity, it must eliminate any eligibility criteria for participation in programs, activities, and services that screen out or tend to screen out persons with disabilities. A public entity must reasonably modify its policies, practices, or procedures to avoid discrimination. If the public entity can demonstrate that a particular modification would fundamentally alter the nature of its service, program, or activity, it is not required to make that modification.

BASIC CONSIDERATIONS (cont.)

A public entity must ensure that individuals with disabilities are not excluded from services, programs, and activities because existing buildings are inaccessible. A State or local government's programs, when viewed in their entirety, must be readily accessible to and usable by individuals with disabilities. This standard, known as *program accessibility,* applies to facilities of a public entity that existed on January 26, 1992. Public entities do not necessarily have to make each of their existing facilities accessible. They may provide program accessibility by a number of methods including alteration of existing facilities, acquisition or construction of additional facilities, relocation of a service or program to an accessible facility, or provision of services at alternate accessible sites.

Definitions

Disability - The ADA definition of *disability* differs from the understanding of a disability that has traditionally been employed by the agency. By *disability* the ADA does not necessarily mean a condition which makes it impossible for a person to be employed. Rather, a person "with a disability" is one who meets any one of the three following criteria:

- The individual has a physical or mental impairment that substantially limits one or more of that person's major life activities.
- The individual has a record of such impairment.
- The individual is regarded as having such impairment.

ADA protection applies primarily to individuals with disabilities. However, a parent with a disabled child may receive protections under the ADA. Also, an individual who assists persons with disabilities in asserting their rights under the ADA may receive protections under the ADA even though the individual providing the assistance may not have a disability.

Meaningful access - The ADA requires that persons with disabilities must be afforded *meaningful access* to the Medicaid program. To provide *meaningful access* is not limited to merely providing physical access to a DFCS office building, though providing physical access is absolutely necessary. Rather, it means that individuals with disabilities must be given the opportunity to benefit from all available resources, services, and activities to the same extent as that given to persons without disabilities.

BASIC CONSIDERATIONS (cont.)

Definitions (cont.)

Reasonable Accommodation - The ADA requires that public entities and employers provide *reasonable accommodation* for a person with a disability. Although the ADA contains no clear definition of *reasonable accommodation*, and no specific limits are established for what is *reasonable*, examples are provided.

The ADA requires that, when necessary, a public entity such as DFCS provide *reasonable accommodation* to an individual with a disability. By providing an accommodation the agency insures that the individual with a disability is able to participate in all programs and receive all benefits and services for which that individual is otherwise eligible. If a modification or adjustment is needed to make that possible, then DFCS must do what is required to make it possible. Providing a reasonable accommodation may take many forms including, but not limited to, policy or procedural modifications, deferral from certain activities, provision of auxiliary aids, extensions of deadlines, and the granting of hardship waivers.

Examples of making reasonable accommodation at the administrative level include making existing facilities readily accessible to and usable by an individual with a disability, acquiring or modifying equipment, or providing qualified readers or interpreters.

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2050 - APPLICATION PROCESSING OVERVIEW

POLICY STATEMENT

The Medicaid application process begins with the agency's receipt of a signed application for assistance and ends with notification to the Assistance Unit (AU) of the eligibility determination.

BASIC CONSIDERATIONS

Request for Information and Application

An inquiry regarding public assistance programs can be made at any time, either in person, by mail, by telephone, or at another designated agency. Information regarding public assistance programs is to be provided to any individual without requiring that an application be filed.

An application is to be provided to anyone who requests one.

An application may be requested in person, by mail, telephone, facsimile, email or at any designated agency.

Who May Apply

Anyone may apply for Medicaid benefits, including the following individuals:

- the individual requesting assistance
- a personal representative (PR) acting on behalf of the applicant. The PR can be a relative, friend, guardian or any person in a position to know the applicant's circumstances
- the parent, specified relative or individual who provides/provided care and control of a child or deceased individual
- an individual acting on behalf of an AU, including a representative of a private law firm or cost recovery company (refer to Cost Recovery and Law Firms in this section)
- a child requesting assistance for himself/herself
- a DMA Medicaid provider for a newborn via DMA Form 527, Newborn Eligibility.

The A/R is the primary source of information for the individuals for whom assistance is requested. The A/R may authorize a PR to apply and interview on his/her behalf, however the A/R is considered the best source of information and must be interviewed to confirm that the information received is correct. This may be accomplished either by a face-to-face interview, by telephone contact or by mail, unless contact is precluded by physical or mental limitations of the A/R.

BASIC CONSIDERATIONS

Who May Apply (cont.)

The A/R may withdraw, at any time, authorization for a PR to act on his/her behalf. This request must be made in writing and signed by the A/R.

NOTE: An application may be filed on behalf of a deceased individual. Refer to Special Considerations in this Section.

The Completed Application

A complete application consists of a signed application submitted with a name and information adequate to contact the applicant or PR. It is **NOT** necessary for the applicant to complete all questions, as missing or incomplete information may be obtained at the time of the interview.

Assist the AU as needed to complete the application form.

The application form may be completed by the applicant, a PR or an agency representative.

An application must be accepted without prior screening or interview.

An individual has the right to file an application on the day of initial request for benefits. The agency will not refuse anyone the right to same day filing. The agency must inform the individual of the right to file an application on the same day s/he or his/her representative contacts the agency in person or by telephone, mail, facsimile or email, expressing interest in obtaining assistance.

If an individual requests an application by mail, the right to same day filing is met if the application is mailed to the individual on the same day s/he makes the request to the agency.

"Right to Same Day Filing" affects the following:

- beginning date for processing standard
- determination of which three prior months may be considered for eligibility.

BASIC CONSIDERATIONS (cont.)

Application Date

The date of application is the date the application form is received by the county office, whether in person, or by mail. When received via internet or facsimile, the date of application is the date the form was transmitted.

EXCEPTION: The application date is the day an application is received by a health department, disproportionate share hospital, public hospital or a federally funded, 330 health center, regardless of when the application is forwarded to the county office for processing.

Application Processing

An application must be registered within 24 hours of receipt by the agency.

Eligibility for Medicaid must be determined under all Classes of Assistance (COA) before an application is denied. Refer to Continuing Medicaid Determination (CMD) in this Section.

Eligibility for Medicaid coverage for the three months prior to the month of application must be explored for every Medicaid application filed.

Completion of the application process is defined as notification to the applicant of the approval or denial of Medicaid benefits.

An individual may withdraw an application for Medicaid at any time during the application process. A withdrawn application must be registered and denied. The applicant must be notified of the disposition of the withdrawn application.

2051 – VERIFICATION

POLICY STATEMENT

Verification is the use of client statements, documents, collateral contacts with a third party, home visits, computer matches and documentation which confirms the accuracy of statements and information.

BASIC CONSIDERATIONS

This verification policy applies at the following times:

- application
- reviews
- interim changes.

An AU may provide verification using any of the following methods:

- through the mail
- in person
- by facsimile or other electronic device
- through a responsible party (RP).

The agency may not require the AU to present verification in person.

Client Statement

Client statement is accepted as verification for all criteria of Family Medicaid except for the following:

- pregnancy
- alienage
- questionable information

Client statement is accepted as verification for all Q-track criteria in ABD Medicaid except when questionable.

The worker must document that the client's statement was accepted or the reason why the information was questionable and the method chosen to verify the information. Annotation of client statement in the verification field is acceptable documentation that client statement is accepted as verification.

BASIC CONSIDERATIONS (cont.)

Third Party Verification

Third party verification includes the following:

- documents – legal agreements, contracts, bills, leases, medical or doctor's statements, prescription receipts, check stubs, employer statements, social security cards, driver's license, etc.
- collateral contacts – an oral or written statement from a third party, contact with a social service agency, etc.
- home visits – visits made by DFCS personnel or other state, local, community or federal agencies to confirm the accuracy of statements and information.
- Documentation – staff recording of AU's statements, information and observations.
- computer matches – SUCCESS interface with other federal, state and local computer systems to compare and provide data regarding AU members.

NOTE: This list is not all-inclusive.

The AU has the primary responsibility for providing verification to support statements or to resolve questionable information. The AU is given 10 days to verify information.

The agency is responsible for assisting clients in obtaining verification when the client requests assistance (refer to Section 2020, ADA Regulations).

The agency must accept reasonable verification.

Documents

When possible, documents are used as the primary source of verification. Documents provide written evidence of the AU's statements. Certain documents or copies of documents are filed in the case record as proof of the AU's circumstances.

BASIC CONSIDERATIONS (cont.)

Collateral Contacts

A collateral contact is an oral or written confirmation of the AU's circumstances by a non-AU member. The collateral contact may be made in person, over the telephone, or in writing.

If a written statement is provided by the collateral contact, the statement must be signed by the individual who wrote the statement. The statement should be dated but, if not dated, DFCS is to date stamp or record on the statement the date it is received. The telephone number and/or address or way to contact the collateral contact must be furnished. This information may be provided as a part of the written collateral statement or recorded in the case file.

If a collateral statement is unacceptable to the agency because it is not completed correctly or lacks the required information and the AU is cooperating with providing information, the agency must offer assistance to the AU. The agency may ask the AU to provide another collateral contact, select another one for the AU or contact the collateral contact directly.

The agency may substitute a home visit or select an alternative form of verification if circumstance warrant.

The agency must make sure that the AU understands what information is needed from the collateral contact. The request for verification form should specify what information is needed and the preferred format.

When taking a collateral statement on the telephone or in person, record in the case file the name address or telephone number of the contact, the date of the contact and the collateral contact's statements regarding the AU.

The agency may select a collateral contact if the AU fails to designate one or designates one which is unacceptable to the agency. Examples of acceptable collateral contacts include employers, landlords, neighbors, social service agencies, etc.

BASIC CONSIDERATIONS (cont.)

When speaking with a collateral contact, the agency must disclose only the information that is absolutely necessary to obtain the information being sought. Avoid disclosing the following information:

- that the AU has applied for benefits
- information supplied by the AU
- information that cannot be released to anyone, including the AU as provided in Section 2010
- that the AU is suspected of any wrong doing.

NOTE: The intent of this policy is to minimize the disclosure of information.

Home Visits

Prearranged home visits may be used as verification. DFCS employees may use home visits if one of the following situations happens:

- third party verification is insufficient to make a firm determination of eligibility
- third party verification cannot be obtained and the AU's statement is questionable.

NOTE: A home visit cannot be made or used as verification solely because an AU fits the profile of an error-prone AU as determined by the agency.

Computer Matches

Refer to Section 2001, Computer Matches Overview, Section 2002, Income and Eligibility Verification System, (IEVS) and Section 2004 Clearinghouse. These sections provide policy regarding verification of case information by computer matching.

Documentation

Case files are documented in accordance with the standard documentation requirements. A written recording of the information and statements provided by the AU is considered verification. This is the AU's statement of its circumstances. The agency may also request that the AU make a separate, written statement to verify and/or clarify a specific point of eligibility. Refer to Appendix B, Documentation Standards.

PROCEDURES

Verify AU information as provided by policy found in this manual.

2052 – CONTINUING MEDICAID DETERMINATION

POLICY STATEMENT

Eligibility must be reviewed under all Medicaid Classes of Assistance (COAs) before denying a Medicaid application or an individual in a Medicaid Assistance Unit (AU) and prior to termination of ongoing Medicaid eligibility for an entire AU or individual in an AU. Individuals who have been terminated SSI will have their Medicaid eligibility redetermined by DFCS before DMA terminates their SSI Medicaid.

BASIC CONSIDERATIONS

Do **not** deny or terminate Medicaid eligibility before completing a Continuing Medicaid Determination (CMD) to consider Medicaid eligibility under all other COAs.

Complete a CMD on all SSI terminations which appear on DMA generated reports. Refer to Chapter 2700, Case Management, for processing instructions on specific DMA reports.

Process the CMD according to which COA is most advantageous to the applicant(s)/recipient(s) (A/Rs).

ABD Medicaid

For ABD Medicaid, consider eligibility under all COAs in the following order:

- FBR COAs
- LA-D/Medicaid CAP COAs
- QMB/SLMB/QDWI, QI-1, QI-2
- AMN

NOTE: QMB, SLMB QI-1 or QI-2 may be approved while the A/R is waiting to meet an ABD Medically Needy spenddown.

QI-1 and QI-2 recipients cannot be dually eligible ongoing with another COA.

BASIC CONSIDERATIONS (cont.)

Family Medicaid

For Family Medicaid, consider eligibility in the following order:

- Newborn
- LIM
- Other Family Medicaid COAs based on LIM eligibility criteria, i.e., TMA, 4MCS
- RSM
- PeachCare for Kids
- Family Medicaid Medically Needy.

NOTE: If all verification requirements are met for RSM PgW and/or RSM Child, eligibility may be approved for either of these COAs while eligibility is being determined under LIM.

NOTE: Medicaid eligibility for a child in foster care is determined first under the IV-E FC program. If ineligible under the IV-E FC program, Medicaid eligibility is determined under CWFC Medicaid.

CMD Application Requirements

A new application is **not** required at CMD when eligibility for a COA is terminated and previously eligible AU members are subsequently approved for another COA.

EXCEPTION: A new application **is** required if the previously eligible AU received a Q-track Medicaid COA (QMB, SLMB, QI-1 or QI-2) based on an application filed using form DCH 700.

A new application **is** required when any individual is added to an existing AU or when a new individual is included in the approval of a new COA as part of the CMD process.

EXCEPTION: A new application is **never** required when approving Newborn Medicaid COA.

CMD Interview Requirements

An interview is required only when a new application is required as part of the CMD process. It may be necessary, however to contact the AU by telephone, by mail or in person if the new COA requires information not included at the time of application for the terminated COA.

PROCEDURES

ABD and Family Medicaid

Follow the steps below to complete a CMD for an ABD or Family Medicaid denial or termination:

STEP 1

Consider eligibility under all COAs (both ABD and Family Medicaid) prior to denial or termination of Medicaid.

STEP 2

Approve Medicaid under the COA that will provide the most medical coverage if the A/R meets all eligibility requirements for the COA.

STEP 3

Deny or terminate Medicaid if the A/R does not meet the requirements for any Medicaid COA.

STEP 4

Notify the A/R of their Medicaid eligibility status via a system generated notice as follows:

- Send **adequate** notice when completing the CMD on an application or changing COAs for a current Medicaid recipient
- Send **timely** notice if the CMD results in termination of Medicaid eligibility or the reduction of Medicaid benefits for a current recipient.

SSI Terminations

Federal Law mandates that a CMD be completed on all SSI terminations before Medicaid can be terminated by DMA. As part of this CMD process, DMA will determine if continued eligibility exists and move the A/R to the new Medicaid coverage group. Reports listing the names of individuals who are converted to a new coverage group will be generated and mailed to local DFCS offices. Refer to Section 2752, Continuing Medicaid Determination Reports, for specific instructions on how to complete the CMD process for an A/R terminated from SSI.

2053 - RETROACTIVE MEDICAID

POLICY STATEMENT

Retroactive Medicaid provides Medicaid coverage for eligible individuals for the following time periods:

- Three months prior to the month of application for ABD Medicaid, Family Medicaid or Supplemental Security Income (SSI).
- Intervening months - the month of application through the month of case disposition for ABD, Family Medicaid or SSI.

BASIC CONSIDERATIONS

Retroactive months include **prior months** and **intervening months**.

Intervening Months

Intervening months are defined as any of the following:

- the month of a Medicaid application through the month of case disposition
- the month of a SSI application through the month of case disposition

Prior Months

Prior months are defined as any of the following:

- the three months prior to the month of a Medicaid application (ABD or Family Medicaid) filed with DFCS
- the three months prior to the month of SSI application for SSI approvals and denials

  NOTE: For DFCS to determine eligibility on a SSI intervening month, the SSI must be denied for a financial or non-financial reason other than failure to meet disability.

Eligibility can be determined for each retroactive/intervening month under any ABD or Family Medicaid class of assistance, regardless of the ongoing disposition of the application.

Potential eligibility for Medicaid for all retroactive/intervening months is protected indefinitely for all Medicaid COAs including SSI. Medicaid can be approved at any time for any retroactive month if all eligibility criteria are met.

BASIC CONSIDERATIONS (cont.)

DFCS does not have to make a determination on the same prior month(s) more than once if the initial determination was a financial denial (over income, over resources, etc.) or a basic eligibility denial (citizenship/alienage, residency, disability, etc.).

EXCEPTION: For retroactive/intervening months, the following criteria are not required:

- enumeration
- application for other benefits
- cooperation with CSE.

Eligibility may be reconsidered for any month in which the denial was for a procedural reason (i.e. failure to provide verification, lack of information, failure to appear for an interview, etc.)

The A/R does not have to be re-interviewed or sign forms that were previously completed for the retroactive/intervening month(s).

Medicaid eligibility is determined only for prior months in which the AU has incurred a Medicaid covered expense that remains unpaid. Verification of the expense is not required.

A CSE referral is not made if Medicaid is approved for retroactive Medicaid only.

Family Medicaid may be requested for the three prior months when adding an individual to a case. The day the request to add an individual is made determines the three prior months time period and is the application date for determining the three months prior.

If an A/R is denied Medicaid because of failure to cooperate with an eligibility requirement, the A/R has also failed to cooperate in the intervening months for the COA under which eligibility is being determined. The A/R may be approved under another COA if compliance with the eligibility requirement is not required for that COA.

BASIC CONSIDERATIONS (cont.)

Prior Months for SSI Applicants

Effective for all SSI applications filed on or after August 22, 1996, Social Security will not issue a SSI check for an eligible individual for the month of SSI application. The first month an A/R will receive a SSI check is the first month following the month of application, or the first month following the month that the individual becomes eligible for SSI with respect to that application, whichever is later. The SSI status for the first month of payment is C01; the SSI status for the preceding month is E02. The process for determining eligibility for prior months is the same for approved and denied SSI applications. The first month of SSI payment is not relevant to prior month(s) eligibility.

The three months prior for an approved or denied SSI application are the three months prior to the month of SSI application.

Determine eligibility for the **first and/or second month(s)** prior to the month of SSI application under any Medicaid COA.

Determine eligibility for the **third month** prior to the month of SSI application under **any** Medicaid COA **except** SSI Medicaid.

Example: If the SSI application month is January, the first prior month is December, second prior month is November and the third prior month is October.

Do **not** determine Medicaid eligibility for any month prior to a SSI application until SSA has completed its determination. Once SSA has made its determination, determine eligibility for the three months prior using the procedures outlined in this section. Abide by decisions made by SSA for intervening months except when ABD Medicaid policies for a particular COA differ from SSI policy.

Determine retroactive ABD Medicaid eligibility through the month of death for the following individuals:

- An individual who dies **prior to** applying for SSI
- An individual who dies **after** applying for SSI.

NOTE: SSA will complete the SSI application process only on a deceased individual who has a surviving spouse. If SSI is approved, SSI will be awarded for the month following the month of application through the month of the A/R's death.

PROCEDURES

Retroactive Months

Follow the steps below to determine retroactive Medicaid eligibility.

Step 1

Conduct a face-to-face interview with the A/R unless previously interviewed.

EXCEPTION: Medicaid applicants may be interviewed by trained non-DFCS staff if the application is filed at the health department, a disproportionate share or public hospital or federally funded health center.

If the A/R is deceased, conduct the interview with a personal representative (PR) acting on their behalf. This person should be knowledgeable about the A/R's circumstances.

Step 2

Determine the AU and BG for each month. Refer to Chapter 2600, Assistance Units, for Family Medicaid.

For ABD Medicaid, determine financial responsibility for each month. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting.

Step 3

Determine for which month(s) retroactive Medicaid is being requested and establish a class of assistance (COA) for each month. Refer to Chapter 2100, Medicaid Classes of Assistance.

Step 4

Establish basic eligibility criteria for each month. Refer to Chapter 2200, Basic Eligibility Criteria.

If the A/R applies for prior months as a disabled individual, disability must be verified for each prior month. Refer to Section 2205, ABD Requirements.

Step 5

Determine financial eligibility for each month. Refer to Chapters 2500, ABD Financial Responsibility and Budgeting and 2650, Family Medicaid Budgeting.

- Use actual income and expenses for prior months.
- Use anticipated income and expenses for intervening months or actual income if available.

If multiple, non-financial changes occur in a retroactive month, use the circumstances on any day of the month that is most advantageous to the AU in determining eligibility

PROCEDURES (cont.)

Step 6 Budget each prior month separately using the budgeting procedures for the COA chosen for that month.

Step 7 Approve Medicaid on the system under the appropriate COA if the A/R meets all eligibility criteria. Deny any ineligible months.

If some (or all) AU members are ineligible, complete a CMD to consider Medicaid eligibility under all other COAs. Refer to Section 2052, Continuing Medicaid Determination.

Complete a Certification of Medicaid Eligibility, either system generated or manually for the approved retroactive month(s).

- Include all retroactive or intervening months and send the original to the A/R.

  NOTE: In MN cases, include the Begin Authorization Date (BAD) and spenddown information, if required.

- File a copy in the case record if completed manually.

- Complete a Form 964 only if the retroactive month(s) cannot be transmitted electronically to DMA (i.e. months are too far in the past to be entered on SUCCESS). If Form 964 is necessary, fax a copy to the Division of Medical Assistance (DMA), (404) 656-9655. Annotate the Form 964, "Please enter manually, cannot transmit via SUCCESS".

2054 – EMERGENCY MEDICAL ASSISTANCE

POLICY STATEMENT	Emergency Medical Assistance (EMA) provides medical coverage to individuals who meet all requirements for a Medicaid Class of Assistance(COA) except for citizenship/alienage and enumeration requirements and who require or have received an emergency medical service.
BASIC CONSIDERATIONS	A non-citizen applicant is potentially eligible for EMA under any Medicaid COA. The applicant must meet all eligibility criteria for the COA with the following exceptions: • citizenship/alienage • enumeration. Approval for EMA will usually be for, but is not limited to a service that was provided prior to the date of application. An eligible individual may be approved for ongoing EMA coverage for the period of time for which a doctor certifies the need for ongoing emergency medical services. Emergency medical services are services provided for the treatment of acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in: • placing the patient's health or the health of an unborn child in serious jeopardy • serious impairment of bodily functions • serious dysfunction of any bodily organ or bodily function. Services can include labor and delivery, from active labor until delivery is complete and mother and baby are stabilized. A physician determines the need for an emergency medical service and verifies that the service has been or will be rendered. The physician verifies emergency medical services by completing DMA Form 526, "Physician's Statement for Emergency Medical Assistance", or other written statement. The written statement must include all information on the DMA Form 526; specifying the date(s) emergency medical service has been or will be rendered.

BASIC CONSIDERATIONS (cont.)

The EW will accept DMA Form 526 and proceed with the eligibility determination, regardless of level or type of medical service rendered. DMA will determine if claims submitted by providers meet the definition of an emergency medical service. Only emergency medical services should be reimbursed.

Georgia residency is required and is established by the A/R's verbal or written statement that s/he lives or has intent to live in the state and is physically present in Georgia.

An application for EMA is processed within 45/60 days. If a person applies for an emergency medical service to be received at a future date more than 45/60 days after the date of application, the application is denied and the applicant may reapply at a later date.

A pregnant woman who is approved for EMA is not eligible for the 60-day pregnancy transition coverage unless there is another medical emergency after the woman has given birth. Normally EMA ceases the day after delivery.

EMA is only approved for the date(s) specified on the DMA Form 526 or physician's written statement. EMA cannot be approved ongoing for more than three months. If EMA services will be needed for longer than three months, obtain a new statement in the third month.

A child born to a woman approved for EMA for the delivery is eligible for Newborn Medicaid.

An EMA A/R has the right to request a Fair Hearing. Refer to Fair Hearings for additional information.

A Continuing Medicaid Determination (CMD) is not required upon termination of EMA.

NOTE: Other family members who meet citizenship/alienage and enumeration requirements can request Medicaid coverage. Follow application procedures appropriate for any other COA for those family members.

BASIC CONSIDERATIONS (cont.)

Determine eligibility and provide notification of case disposition within the following SOPs:

- within 10 days for pregnant women
- within 45 days for Family Medicaid COAs and ABD COAs for aged and blind applicants
- within 60 days for ABD COAs for disabled applicants

PROCEDURES

Follow the steps below to approve EMA.

Step 1 Obtain a signed application from the A/R and determine the appropriate COA under which EMA will be processed. Conduct a face-to-face interview.

NOTE: A face-to-face interview is not a requirement if EMA is processed under RSM.

Step 2 Determine the AU and BG and complete the budgeting process for the appropriate COA.

Step 3 Establish basic eligibility for the BG with the exception of citizenship/alienage and enumeration.

Step 4 Obtain DMA Form 526 or a written, signed statement from the physician verifying the need for emergency medical services.

NOTE: If DMA Form 526 or physician's statement indicates emergency medical services will be needed for longer than three months, obtain a new Form 526 or statement in the third month and every third month thereafter until the end of the emergency medical services.

PROCEDURES (cont.)

Step 5 Approve the case using the appropriate COA if the A/R meets all eligibility criteria. Notify the AU of the eligibility determination. The notice should include the following:

- approval/disposition date
- Medicaid ID number
- Date(s) of eligibility

Step 6 If EMA is approved ongoing, in the third month obtain a new Form 526 or physician's statement verifying whether EMA services will continue and the anticipated time period. Update SUCCESS with the new EMA period of eligibility.

Step 7 A review is required prior to approving EMA beyond the initial 6 months, and each 6 month period thereafter.

NOTE: A new DMA form 526 or physician's statement is required **every third month** to verify that emergency services will continue to be needed. Ongoing Medicaid eligibility is **not** to be continued without verification of new period of eligibility for emergency services.

Step 8 At the point the A/R is no longer eligible for emergency services, terminate eligibility. Provide timely, written notification to the AU indicating the reason for termination and the effective date. A CMD is not required.

PHYSICIAN'S STATEMENT
FOR
EMERGENCY MEDICAL ASSISTANCE

Patient's Name: _____

Patient's Address: _____

Patient's Telephone #: _____

Individuals who do not meet Medicaid citizenship/alienage requirements may be eligible for Emergency Medical Assistance (EMA). EMA provides payment for treatment of emergency services only. A **medical emergency** is defined as having:

> "**Acute symptoms** of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
> - Placing the patient's health in serious jeopardy;
> - Serious impairment to bodily functions; or
> - Serious dysfunction of any bodily organ or part."

The individual will have to be determined eligible for Emergency Medical Assistance under one of the Department's existing regular Medicaid coverage groups:

- Aged, blind or disabled;
- Pregnant women; or
- Children under 19 years of age.

I provided EMERGENCY medical services on _____ through _____
(Date of onset) (Date emergency ended)

for the individual listed above.

The above patient will require EMERGENCY medical services from_____

through _____.
(Not to exceed 3 months from condition onset date)

_____ _____
(Provider's Name) (Provider or Authorized Designee's Signature)

_____ _____
(Provider's Address) (Date)

2055 – SPONSORED ALIENS

POLICY STATEMENT

Aliens who are ineligible for SSI because of income or resources deemed from a sponsor may be determined eligible for Medicaid without considering the income or resources of the sponsor.

BASIC CONSIDERATIONS

Aliens who are admitted to the United States as permanent residents often have a sponsor. The income and resources of a sponsor and his/her spouse are used by SSI in determining the financial eligibility of an alien.

The Social Security Administration (SSA) deems the sponsor's income and resources in the SSI eligibility determination for up to five years. The five-year period begins with the month the alien is admitted to the U.S. for permanent residence or is granted permanent resident status.

SSA may waive deeming from the sponsor when the alien's disability or blindness begins at either of the following points:

- After entry into the U.S. for permanent residence
- After becoming a permanent resident.

NOTE: The income and resources of a sponsor are not considered in Family Medicaid budgeting.

PROCEDURES

Follow the steps below to process the Medicaid application of a sponsored alien.

Step 1 Verify the alien's SSI application was denied based on the sponsor's income or resources.

If the A/R is denied SSI solely due to the sponsor's deemed income or resources, consider eligibility for Medicaid under any class of assistance, including SSI Medicaid.

Step 2 Determine eligibility for Medicaid without considering the income and resources of the sponsor. Consider retroactive and ongoing eligibility.

NOTE: A reduction in the income and resources of the sponsor, the sponsor's spouse or the A/R may make the A/R eligible for SSI. Remind the A/R and sponsor to report changes in financial circumstances.

PROCEDURES (cont.)

Step 3	Verify the month SSI will stop counting the income and resources of the sponsor.
Step 4	Complete the CMD at least one month before the month SSI will stop counting the income and resources of the sponsor to determine if the alien is SSI eligible or eligible under a COA other than SSI Medicaid. Refer to Section 2052, Continuing Medicaid Determination.

2060 – ABD MEDICAID APPLICATION PROCESSING

POLICY STATEMENT	The ABD Medicaid application process begins with the request for medical assistance and ends with written notification to the A/R of the eligibility determination.
BASIC CONSIDERATIONS	Eligibility for ABD Medicaid is determined in the following order: • FBR COAs • LA-D/ Medicaid Cap COAs • QMB/SLMB/QDWI/QI-1/QI-2 • ABD Medically Needy. **NOTE:** QMB/SLMB/QI-1 AND QI-2 may be approved while the A/R is waiting to meet an Adult Medically Need Spenddown. QI-1 and QI-2 cannot be dually eligible ongoing with another COA. An application is processed at the DFCS office located in the county where the applicant resides. If an A/R is confined to a nursing home or swing bed, the application is processed in the county where the nursing home/swing bed is located. However, if at the time the application is received the A/R is no longer in that facility, the county where the A/R currently resides processes the application. If the A/R is applying under the Hospital COA, the application is processed in the county in which the A/R resided prior to entering the hospital. However, the DFCS office in the county where a hospital is located may opt to process an application that has been received from the hospital. The application date is the date a signed application is first received in any county DFCS office.

PROCEDURES

Application Requirements

An application for ABD Medicaid is defined as any of following:

- Form 297
- SUCCESS Application for Assistance (AFA)
- DCH Form 700 (for QMB, SLMB, QI-1 and QI-2 only)
- Internet Medicaid Application

A completed application consists of a signed application with information sufficient to contact the A/R or PR. Any other information that is missing, incomplete or otherwise unclear may be obtained from the A/R or PR after the signed application is received and registered in the system by the agency.

Application Screening

Screen the application to determine the following:

- Current receipt of the benefits for which the A/R is applying
- Current receipt of other benefits available through the agency.

Who Must be Interviewed

The A/R is considered to be the primary source of information. The A/R may authorize a PR to apply and interview on his/her behalf. However, the A/R is considered the best source of information and every attempt should be made to interview the A/R. If information provided by a PR is questionable or unclear, attempt to contact the A/R by telephone or mail for clarification, unless contact is precluded by physical or mental limitations of the A/R.

Interview Requirements

Conduct an interview with the A/R and/or PR, either face-to-face or by telephone depending on which COA is being applied for, prior to disposition of the application.

EXCEPTION: A face to face or telephone interview is not required for applicants of QMB, SLMB, QI-1 or QI-2.

Conduct a home visit when the A/R is unable to come to the office because of the following reasons:

- Illness
- Physical or mental handicap
- Lack of transportation
- Undue hardship.

Orally or in writing, inform the A/R about the Medicaid program(s) for which s/he may be entitled by use of appropriate information pamphlets or other printed material.

PROCEDURES (cont.)

What the Interview Must Include

Explain the following information during the interview:

- The services provided by DFCS and the right to apply for them
- Requirements of eligibility and the A/R's responsibility to provide information to establish eligibility and benefit level, including the following:
  - basic eligibility requirements
  - financial requirements
  - periodic reviews
  - timely reporting of changes
  - assignment of TPR
  - medically needy requirements, if applicable
  - vendor payment/cost share, if applicable
- The applicant's right to the following:
  - a fair hearing
  - prompt action within the standard of promptness (SOP)
  - confidentiality
  - non-discrimination in the processing of the application
  - services available to the family from other agencies

Mandatory Forms

Complete the mandatory forms below when processing an ABD Medicaid application:

- Form 297 or other application for assistance
- Form DMA 285, Third Party Liability Health Insurance Questionnaire (if the A/R reports a TPL)
- Form 297-A, Rights and Responsibilities

EXCEPTION: Form DMA-285 is not required when the application is Form DCH 700. Send a copy of Form 700 to DMA/TPL in lieu of Form DMA-285 if the client has medical insurance. Attach a copy of the insurance card, front and back, if available.

PROCEDURES (cont.)

Other Required Action for ABD

Complete any other mandatory forms necessary depending on the COA and the A/R's circumstances.

Determine if the A/R meets all points of eligibility.

Complete mandatory clearinghouse requirements.

Follow appropriate documentation standards for ABD Medicaid.

Explore Medicaid eligibility for the three prior months.

Obtain required verification.

ABD Medicaid Standard of Promptness (SOP)

Determine eligibility and provide notification of the disposition of the application within the appropriate SOP:

- 45 calendar days beginning with the application date for aged or blind applicants.
- 60 calendar days beginning with the application date for disabled applicants.
- 10 working days beginning with the application date for all QMB, SLMB, QI-1 and QI-2 applicants.

NOTE: If the deadline falls on a weekend or holiday, complete the application by the last workday prior to the weekend or holiday.

PROCEDURES (cont.)

Application Processing Standards for ABD Medicaid

Observe the following standards in processing applications:

- Register the application in the system within 24 hours of the agency accepting the application.
- If the A/R or PR is not interviewed on the same day the application is filed, schedule the interview within a reasonable timeframe. An appointment notice, if mailed, must be sent to the A/R no later than 10 days prior to the scheduled appointment. A copy may also be mailed to the PR at the request of the A/R. If necessary, schedule a home visit.
- Reschedule the appointment if the A/R or PR contacts the agency to reschedule the appointment prior to the interview. Do not consider the original appointment a missed appointment.
- If the A/R or PR fails to keep a scheduled appointment and has not contacted the agency to reschedule, deny the application.
- If the A/R or PR contacts the agency within 30 days of missing a scheduled appointment and the application has been denied, reschedule a second appointment using the original application date if good cause can be established for failing to meet the first appointment.

  NOTE: Examples of good cause are illness, hospitalization, lack of transportation, mental or physical handicap or any other reason deemed appropriate by the EW.
- If it is determined that additional information will be required, complete a verification checklist and give to the A/R or PR at the interview. Mail if the interview was done by telephone. Establish a reasonable deadline for returning requested verification.

PROCEDURES

Application Processing Standards for ABD Medicaid (cont.)

- If the A/R or PR fails to meet the deadline for providing additional information, make contact to assess the need for an extension of the deadline or the possibility of assisting in obtaining required verification.

  NOTE: Do **not** deny an application for failure to provide verification if the verification can be requested or obtained by the EW.

- Contact the nursing home or case manager by the 30th calendar day from the application date if Form DMA-6, DMA-59, Form 5590 or other appropriate communicator has not been received. Document and follow-up as necessary.

- Deny the application at the first point ineligibility is established. Do **not** leave a case pending in anticipation of the A/R becoming eligible at a future date beyond the ongoing benefit month.

- Deny the application within two days of SOP if the nursing home or case manager has failed to submit Form DMA-6, Form 5590 or other appropriate communicator to Georgia Medical Care Foundation (GMCF) or other authorized approval source.

  NOTE: If GMCF or other approval source has received the form but has not yet completed it, do **not** deny the application.

Use the following guidelines to determine whether to process an application within the appropriate SOP:

- Do **not** deny an application solely because the 45th/60th/10th day has been reached and eligibility cannot yet be determined.

Deny an application before the SOP if the A/R or PR fails to cooperate in the application process or in supplying necessary information which they are capable of obtaining and DFCS has **no** means of obtaining directly.

PROCEDURES (cont.)

Disposition of the Application

Determine if the A/R meets all points of eligibility.

Process applications in chronological order, with the exception of QMB/SLMB/QI-1/QI-2 applications, based on the following:

- date of application
- whether all information is available to determine eligibility.

NOTE: Follow the 10-day SOP guidelines for QMB/SLMB/QI-1/QI-2 applications.

If eligible, approve the application ongoing and for any retroactive months, if appropriate.

Notification

Provide adequate notification to the A/R via the system of the eligibility determination. A copy may also be sent to a PR at the request of the A/R. Adequate notification includes the reason(s) for any action taken.

The system-generated notice must include the following:

- the basis for the approval/denial/termination
- the period of eligibility
- the reason for the action
- the A/R's right to request a fair hearing
- the telephone number of the county DFCS office
- the telephone number of legal services
- the amount of medical expenses required to meet the ABD Medically Needy Spenddown if the A/R meets all eligibility requirements other than income.

Generic denial reasons such as *call your caseworker* may be used as a secondary or tertiary denial/termination reason, but never as the sole reason for denial/termination.

Period of Eligibility

Approve Medicaid and continue eligibility as long as the A/R continues to meet the requirements of the COA under which they are approved. A CMD must be completed prior to denial or termination of any Medicaid COA. Refer to Section 2052, Continuing Medicaid Determination.

EXCEPTION: A COA, which has been approved using EMA criteria, does not require a CMD when denied or terminated.

PROCEDURES (cont.)

Property Search Requirements

Conduct a property search on required ABD Medicaid applicants for the following reasons:

- to verify the value and status of all real property in which the A/R and/or deemor declare an ownership interest.
- to detect any undisclosed property in which the A/R and/or deemor may have an ownership interest.
- to detect and/or verify any transfer of real property affected by the A/R.

A search of the tax digest and grantee/grantor records is **no** longer required for applicants entering the nursing home and/or applying under a home/community based waiver program.

A property search must be completed, however, if a questionable situation regarding ownership of property is discovered in the eligibility determination process.

If deemed necessary, conduct a property search by checking the current tax digest and transfers for the past 36 months in the grantee/grantor book for the county in which the A/R resides or did reside prior to entering LA-D.

A search of the tax digest is **not** required if the A/R has not lived in Georgia during the 24 months prior to the month of application.

A search of the grantee/grantor book is **not** required if the A/R applies under a COA that does not require the imposition of a penalty for a transfer of resources.

A search of the tax digest and grantee/grantor records is **not** required if the A/R is applying for QMB, SLMB, QI-1 or QI-2.

Out of County Property Search

Request assistance in completing a property search from the DFCS office in another county where the client may have resided for a substantial period of time before moving to the current county of residence using Form 991, MAO Property Record Search. Review the exceptions to property search requirements to determine the necessity for a property search.

PROCEDURES (cont.)

Out of State Property Search

Conduct an out of state property search using Form 991 only if one of the following situations occurs:

- The A/R alleges having a current ownership interest in real property located in a state other than Georgia.
- The A/R alleges having sold real property located in a state other than Georgia, and the A/R cannot give a reasonable account of the disposition of the proceeds from the sale.

SPECIAL CONSIDERATIONS FOR SSI APPLICANTS

The Social Security Administration (SSA) accepts and processes applications for Supplemental Security Income (SSI) at local SSA offices. Any individual applying for ABD Medicaid at DFCS who appears to be financially eligible for SSI must be referred to the local SSA office to file an application. The ABD Medicaid application would be denied pending the outcome of the SSI application.

SSI applicants have the right to have any month for which they have been determined ineligible for a SSI payment for a reason other than failure to meet the disability criteria examined for eligibility under ABD Medicaid. Refer to Section 2053, Retroactive Medicaid.

DFCS is responsible for determining Medicaid eligibility on SSI applicants for the following months:

- the three months prior to the month of SSI application for SSI approvals and denials
- intervening months associated with a SSI application for which the applicant is ineligible for a SSI payment for a reason other than failure to meet disability.

A SSI applicant who wants a determination of ABD Medicaid eligibility for intervening months must contact DFCS within 30 days of receipt of the DMA notice informing him/her of the disposition of the SSI/Medicaid application.

Refer to Section 2053, Retroactive Medicaid, for processing procedures for retroactive months associated with a SSI application.

2065 – FAMILY MEDICAID APPLICATION PROCESSING

POLICY STATEMENT

The Family Medicaid application process begins with the request for public assistance and ends with notification to the Assistance Unit (AU) of its eligibility status.

BASIC CONSIDERATIONS

Order of Eligibility

Eligibility for Family Medicaid is determined in the following order:

- Newborn
- LIM
- other Family Medicaid COAs based on LIM eligibility criteria, i.e., TMA, 4MCS
- RSM
- PeachCare for Kids
- Family Medicaid Medically Needy.

NOTE: Medicaid eligibility for a child in foster care is determined first under the IV-E FC program. If ineligible under the IV-E FC program, Medicaid eligibility is determined under CWFC Medicaid.

Application Requirements

A Medicaid application is defined as any one of the following:

- Form 297
- SUCCESS Application for Assistance (AFA)
- PeachCare for Kids application
- Right from the Start Medicaid application (used primarily by health departments in conjunction with Presumptive Eligibility forms)
- Internet Medicaid application.

A completed application consists of a signed application with information sufficient to contact the applicant or responsible party (PR). Any other information that is missing, incomplete or otherwise unclear may be obtained from the applicant or PR after the signed application is received and logged by the agency.

NOTE: Homeless AUs are **NOT** required to provide an actual address, but must provide sufficient information to establish Georgia residency. The applicant's statement is acceptable unless conflicting information is known to the agency.

BASIC CONSIDERATIONS (cont.)

Application Screening

Screen the application to determine the following:

- current receipt of the benefits for which the AU is applying
- current receipt of other benefits.

Who Must be Interviewed

The applicant/recipient (A/R) is the primary source of information for the individual(s) for whom assistance is requested. The A/R may authorize a PR to apply and interview on his/her behalf; however, the A/R is considered the best source of information. Contact the A/R by telephone or mail to confirm that correct information has been received if the interview was attended by a PR, unless contact is precluded by physical or mental limitations of the A/R.

Scheduling the Interview

A face-to-face (FTF) interview with the Family Medicaid applicant or PR must be completed by a trained DFCS staff member prior to approval of the Medicaid application. A FTF interview may be conducted in the office or may be prearranged as a home visit.

EXCEPTION: A FTF interview is **NOT** required for RSM child and RSM PgW COAs. A FTF interview **MAY** be conducted if it is in the best interest of the applicant. The RSM application may **not**, however, be denied because of applicant failure to attend a FTF interview.

The FTF requirement is met for applicants who apply for Medicaid and are interviewed by trained personnel from a public health center, public or disproportionate share hospital or federally funded (330) health center.

For applications in which a FTF interview is not required, contact the applicant or PR by telephone or mail if additional information is needed to complete the application.

Interview the applicant or PR on the same day the application is filed, when possible.

BASIC CONSIDERATIONS

Scheduling the Interview (cont.)

Follow the procedures below when an applicant is given an appointment for a scheduled interview at a later date.

- accept the signed application on the day the application is received by the agency.
- register the application date as the date the application was received by the agency.
- schedule the interview within a reasonable time and for a time that is convenient for the A/R and/or PR. An appointment notice, if mailed, must be sent no less than 10 days prior to the scheduled appointment.
- mail the appointment to the A/R. Mail a duplicate appointment notice to he PR, if applicable. The appointment notice must **always** be sent to the applicant, even if the applicant indicates s/he cannot attend the appointment with the PR.
- schedule a home visit if the applicant is unable to attend an office interview for any of the following reasons:
  - illness
  - physical or mental handicap
  - lack of transportation
  - undue hardship
  - any other reason deemed appropriate.
- reschedule the appointment if the A/R and/or PR request a rescheduled appointment prior to the interview. Do not consider the original appointment a missed appointment.

BASIC CONSIDERATIONS

Scheduling the Interview (cont.)

- hold the application for 10 calendar days following a missed appointment to allow the A/R or PR to contact the agency. If contact is made and a new appointment is requested, attempt to reschedule to ensure sufficient processing time within the SOP.

- Deny the application the first workday following the tenth day if no contact is made or immediately following a missed rescheduled appointment.

Interview Requirements

Explain the following information during the interview:

- services provided by DFCS and how to obtain those services
- requirements of eligibility and the A/R's responsibility to provide correct information to establish eligibility
- basic and financial eligibility requirements
- lump sum and the effect of lump sums on eligibility
- Clearinghouse requirements
- potential Medicaid COAs
- potential coverage for three months prior to the month of application
- periodic reviews
- timely reporting of changes and how/where changes are to be reported
- assignment of TPR
- the role of Child Support Enforcement, the assignment of medical support rights to the State and Good Cause for non-compliance
- the evaluation of financial management based on available income and expenses and the requirement to resolve or explain any discrepancies

EXCEPTION: Evaluation of financial management is not required for RSM COAs.

BASIC CONSIDERATIONS

Interview Requirements (cont.)

- the A/R's right to the following:
  - a fair hearing
  - a decision within SOP
  - confidentiality
  - non-discrimination.

In addition, explain the following to an AU that includes a pregnant woman:

- the right to apply and how to apply for TANF 45 days prior to the expected date of delivery
- continuous financial eligibility for the pregnant woman
- presumptive eligibility Medicaid process and how to apply at a public health facility if the Medicaid eligibility determination for the pregnant woman cannot be made the same day that the application is filed.

Inform the A/R about the Medicaid program verbally and in writing, by use of available information pamphlets or other printed materials.

Refer the A/R to other appropriate services such as family planning, Health Check and WIC as requested by the applicant or as determined by the agency. Refer to Chapter 2900, Referrals.

Mandatory Forms

Complete the mandatory forms below when processing a Family Medicaid application:

- Application for Assistance
- Eligibility Determination Document or other written interview form
- Form DMA-285, Third Party Liability Health Insurance Questionnaire (if A/R reports a TPL)
- Form 138, Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Enforcement (if a CSE referral is required)

BASIC CONSIDERATIONS

Mandatory Forms (cont.)

- Form 297A Rights and Responsibilities

  NOTE: For applications completed by approved, non-DFCS staff and for COAs in which a FTF is not required, Form 297A may be mailed to the AU. Document the date that the 297A was mailed. It is not required that the mailed 297A to be returned and filed in the case record.

- Form 354, Expense Statement

  EXCEPTION: Form 354 is not required for RSM COAs.

Complete other forms as necessary based on the AU's circumstances.

Verification

Verify information, if required, to determine eligibility for the COA as follows:

- Determine if verification is available from agency sources prior to requesting verification from the AU.
- Requests for verification may be made verbally, but must also be made in writing. The request for verification is provided to the A/R and, if applicable, the PR.
- Inform the applicant of any contacts that will be made with the source by the agency.
- Allow sufficient time for the A/R to obtain verification
- Allow additional time if requested by the AR, within the SOP, to provide verification.
- Consider verification received for one program to be received for all programs.
- Accept the AR's statement as verification when allowed by policy.
- Do not require verification if the A/R's statement establishes ineligibility.

The AR's statement of the source and amount of income, dependent care expenses and resources may be accepted unless the AR's statement conflicts with information known to the agency, or is otherwise questionable.

Pregnancy must be verified for RSM PgW. A/R statement of estimated due date is accepted. Refer to Section 2184, RSM Pregnant Woman.

BASIC CONSIDERATION

Verification (cont.)

Alienage must be verified for all Medicaid COAs except EMA for non-citizen AU members

Verification must be requested for any information provided by the A/R that conflicts with information known to the agency, or that is otherwise questionable. Document the reason that the information is conflicting/questionable.

Disposition of the Application

Determine if the AU meets all points of eligibility.

Process applications in chronological order, with the exception of Medicaid coverage for pregnant women, based on the following:

- date of application
- whether all information is available to determine eligibility

If eligible, approve the application, within 45 days, for all eligible months including retroactive and ongoing months. Process applications for pregnant women within 10 days to ensure early prenatal care.

Notification

Provide the applicant adequate written notification of the eligibility determination. Adequate notification includes the reason(s) for any action taken.

A duplicate notification may be provided to the PR upon request by the A/R. However, the applicant must receive all notices regarding his/her case(s).

Notification must explain the following:

- the basis for the approval/denial/termination
- the period of eligibility
- the reason for the action
- the AU's right to request a fair hearing
- the telephone number of the county DFCS office
- the telephone number of legal services.

Generic denial reasons, such as "call your caseworker" may be used as a secondary or tertiary denial/termination reason, but never as the sole reason for denial/termination

BASIC CONSIDERATIONS (cont.)

Standard of Promptness

The eligibility determination for Family Medicaid COAs must be completed within the following Standards of Promptness (SOP):

- 10 days from the date of application for pregnant women, regardless of COA
- 45 days for EMA-PgW **only** if the application is filed **after** delivery
- 10 days from the date of report for newborns, regardless of COA
- 45 days from the date of application for all other Family Medicaid COAs

Calculate the SOP beginning with the date of application.

Finalize the application by the appropriate SOP date. If the SOP date falls on a weekend or holiday, process as follows:

- complete approvals no later than the last workday prior to the weekend or holiday on which the SOP falls
- complete denials no later than the first workday following the weekend or holiday on which the SOP falls.

Periods of Eligibility

Approve Medicaid and continue eligibility as long as the AU continues to meet the requirements of the COA under which they are approved. A Continuing Medicaid Determination (CMD) must be completed prior to denial or termination of any Medicaid COA. Refer to Section 2052, Continuing Medicaid Determination.

NOTE: Certain COAs are time limited. Refer to Chapter 2100, Classes of Assistance.

2066 – PLACEMENT OUTSIDE THE HOME (FAMILY MEDICAID)

POLICY STATEMENT

An individual living in a placement outside the home may, under certain circumstances be eligible for Family Medicaid.

BASIC CONSIDERATIONS

Who May be Eligible

An individual is **potentially eligible** for Medicaid if any one of the following situations exist:

- an individual admitted to a medical institution to receive medical care

  NOTE: An individual incarcerated or placed in a detention facility who is admitted to a medical treatment facility is considered a resident of the detention facility and is therefore ineligible for Medicaid.

- an individual in a private community facility such as a homeless shelter or a shelter for victims of domestic violence
- a child in a private child care institution that provides 24-hour non-secure custodial care, such as a children's home
- a child in a family licensed home supervised by the Department of Juvenile Justice (DJJ)
- an child in a private licensed group home
- a child in a family foster home approved by one of the following agencies:

  - DFCS
  - Child Services and Family Counseling
  - The United Methodist Children's Home
  - The Georgia Baptist Children's Home (Palmetto Campus)
  - DJJ(as contract home or attention home)

  NOTE: Social Services verifies that a placement has been made in an approved facility.

- an individual in a licensed emergency shelter
- a child placed in any other public or private agency, which DFCS approves for placement.

BASIC CONSIDERATIONS (cont.)

Public Institution

For Medicaid eligibility purposes, the following placement facilities are *not* considered public institutions:

- public educational or vocational training institution
- publicly operated general hospital
- publicly operated nursing home
- publicly operated community residence or group home that serves no more than 16 individuals
- public child care institution that accommodates no more than 25 children and the child is approved to receive Title IV-E foster care payments
- an intermediate care facility for the mentally disabled (nursing home unit), even if located on the premises of a public institution

Who is Ineligible

An individual is **ineligible** for Family Medicaid if any of the following situations exist:

- the individual is incarcerated in a jail, prison or other facility operated primarily for detention
- a child is placed in a detention facility, such as a Youth Development Center (YDC)

  EXCEPTION: A child placed temporarily in a Regional YDC while awaiting transfer to a private facility may be eligible for Medicaid.

- the individual is placed in a public institution

  EXCEPTION: If the placement in the public institution is temporary while awaiting a private placement more appropriate to the needs of the individual, the individual is potentially eligible for Medicaid.

- the individual is legally committed to an institution, whether public or private
- the individual is placed in an institution operated for the treatment of mental illnesses or the treatment of tuberculosis

BASIC CONSIDERATIONS (cont.)

Children Placed Out-of-State

A child placed by a state agency in an out-of-state institution or licensed foster care facility is considered a legal resident of the state making the placement.

The state of origin is responsible for the medical expenses of the child.

EXCEPTION: If the child is IV-E eligible and IV-E payments are made, the child can be approved for Medicaid in the state where the child is placed. Refer to Chapter 2800 for IV-E Foster Care/Adoption Assistance policy.

The placement facility may locate a local doctor, dentist or other medical provider who will enroll as a Medicaid provider in the state of origin.

NOTE: If no providers are willing to enroll for the other state's Medicaid, notify the state office Medicaid Policy Unit.

Private Placement of a Child

A child placed by a parent or other responsible adult in a private placement facility may be eligible for Family Medicaid.

The child placed in a private childcare (residential) institution is considered as an AU of one (1) and no longer in the home of the family.

Refer to Chapter 2600, Family Medicaid AUs and BGs.

NOTE: Budget any money received by the facility for the child. If the parents provide money, it is considered child support and the $50 child support deduction is allowed. If another responsible adult provides money, it is considered a contribution.

Use the following chart of situations to determine if an individual is potentially eligible for Family Medicaid based on current living arrangement outside the home:

CHART 2066.1 INDIVIDUALS IN PLACEMENT OUTSIDE THE HOME	
Situation	Medicaid Eligibility
If the individual is placed in:	Then s/he is Medicaid
a public institution **EXCEPTION:** Temporary arrangement awaiting a more appropriate placement for his/her needs in a private facility	ineligible --- eligible
a public childcare institution that accommodates no more than 25 children and the child is receiving Title IV-E foster care payments	eligible
a publicly operated community residence or group living home that serves no more than 16 individuals (example: residential drug treatment center operated by the Mental Health Division of DHR)	eligible
a public educational or vocational training institution	eligible
a publicly operated general hospital	eligible
a publicly operated nursing home	eligible
a Regional Youth Detention Center operated by DJJ	eligible
a prison or jail or other incarceration or other facility operated primarily for detention	ineligible
a Youth Detention Center	ineligible
a public or private placement of legal commitment through court proceedings	ineligible
an institution operated for the treatment of mental diseases or tuberculosis	ineligible
a medical institution to receive medical care, such as a hospital	eligible

CHART 2066.1 INDIVIDUALS IN PLACEMENT OUTSIDE THE HOME (CONT.)	
Situation	Medicaid Eligibility
If the individual is placed in:	Then s/he is Medicaid
a private community facility such as a battered women's or homeless shelter	eligible
an intermediate care facility for the mentally retarded (nursing home unit) even if located on the premises of a public institution	eligible
a private licensed group home	eligible
a private child care institution that provides 24-hour non-secure custodial care, such as a children's home **NOTE:** Consider the child an AU of one. Budget any money received by the facility for the child as income to the child. If the parents provide money, allow the $50 child support deduction.	eligible
an attention home operated by the DJJ	eligible
a contract home operated by the DJJ	eligible
a family foster home approved by DFCS or DJJ, Families First, Inc., United Methodist Children's Home, Georgia Baptist Children's Home (Palmetto) can use any other public or private agency which DFCS may approve for placement	eligible
a licensed private emergency shelter	eligible
an institution or foster care home in the state of Georgia by another state agency **EXCEPTION:** The child is IV-E eligible and receiving IV-E per diem in placement in Georgia.	ineligible --- eligible

2067 – PRESUMPTIVE ELIGIBILITY (FAMILY MEDICAID)

POLICY STATEMENT	Presumptive Eligibility (PE) Medicaid allows Qualified Providers (QP), authorized by the Division of Medical Assistance (DMA), to make temporary determinations of Medicaid eligibility for pregnant women whose statement of gross BG income is equal to or less than 235% of the Federal Poverty Level (FPL). PE continues while a formal determination of eligibility for Medicaid is pending with DFCS.
BASIC CONSIDERATIONS	PE Medicaid provides outpatient prenatal care to pregnant women during the period that a formal Medicaid application pends with DFCS. All Medicaid services given by any participating Medicaid provider are covered during the presumptive period with exceptions of inpatient hospital and delivery services. The PE Medicaid eligibility period begins the first day of the month in which the QP determines the woman is eligible and ends the last day of the month in which DFCS either approves or denies Medicaid. DMA issues PE Medicaid cards to the pregnant woman until DFCS completes a formal determination of eligibility. If the recipient loses her PE Medicaid card or the PE Medicaid card is not received, the QP is responsible for issuance of a duplicate, temporary Medicaid card. DFCS staff cannot process applications for PE or issue eligibility forms for PE. Potential Qualified Providers include county health departments, federally funded health centers, primary care centers receiving migrant funding and/or homeless funding, hospital outpatient clinics and hospital-based special prenatal clinics.

PROCEDURES

Responsibilities of a Qualified Provider

The QP determines eligibility for PE Medicaid based on a medically verified pregnancy and the countable income of the budget group (BG). The QP conducts a face-to-face (FTF) interview with the pregnant woman and performs the following functions:

- advises the pregnant woman that she may be eligible for Medicaid benefits as a presumptively eligible pregnant woman and as a RSM pregnant woman for ongoing and retroactive Medicaid coverage
- accepts the pregnant woman's statement of income and obtains adequate information from her to complete the following forms:
  - Form DMA-632, Presumptive Eligibility Determination for Pregnancy-Related Care: Medicaid Worksheet
  - "Right From The Start Medicaid Application:(abbreviated version)
  - Form DMA-285, Third Party Liability Health Insurance Information Questionnaire
- determines if the pregnant woman meets eligibility criteria for PE Medicaid.

If the QP determines that the woman is eligible for PE Medicaid, the QP completes the determination process as follows:

- provides the pregnant woman with a copy of the signed and completed PE Medicaid Worksheet

  NOTE: The worksheet will serve as the initial month Medicaid certification.

- obtains adequate information to complete the RSM application form and the Form DMA-285
- provides the pregnant woman with the form, "DMA Notice of Action", explaining the action taken and the involvement of DFCS in the determination process
- forwards the following three forms to DFCS within five working days of the pregnant woman's application:
  - Form DMA-632
  - a signed and completed RSM application
  - a signed and completed Form DMA-285

PROCEDURES

Responsibilities of a Qualified Provider (cont.)

- informs the pregnant woman of the PE Medicaid time limit and covered services
- provides the pregnant woman with the address and telephone number of the local county DFCS office where the application will be sent.

NOTE: To ensure that RSM applications for pregnant women are processed within the 10 day standard of promptness, each county DFCS should negotiate a process with the local QP(s) to forward applications to DFCS daily.

If the QP determines that the pregnant woman is ineligible for PE Medicaid, the QP completes the determination process as follows:

- informs the woman that she is not eligible and provides her with the form "DMA Notice of Action", explaining the action taken and the role of the local county DFCS
- advises the woman that if her circumstances change, she may have another determination of PE Medicaid completed by a QP
- informs the pregnant woman that her application for Medicaid will be forwarded to the local county DFCS for a formal determination of eligibility
- forwards the following three forms to DFCS:

  - the PE Medicaid Worksheet
  - a signed and completed RSM application form
  - a signed and completed Form DMA-285

- provides the pregnant woman with the address and telephone number of the local county DFCS office.

Responsibilities of DFCS

Upon receipt of the PE Medicaid packet, complete a formal determination for Medicaid eligibility for the pregnant woman and any other individuals for whom Medicaid is requested.

NOTE: The application date is the date the applicant applies for benefits with the QP and signs the RSM application form.

Process the PE as LIM or RSM Pregnant Woman. Refer to Sections 2162, LIM and 2184, RSM Pregnant Woman.

2068 – SPECIAL CONSIDERATIONS

Applications at a Non-DFCS Site

DFCS workers are outstationed at certain public health centers, disproportionate share or public hospitals and federally funded health centers to expedite the processing of applications for Medicaid. These workers process the Medicaid applications as if taken at the DFCS office.

Medicaid applications are taken at sites other than DFCS by the facility's personnel. The facility workers are trained by DFCS to accept applications and conduct face-to-face (FTF) interviews.

If the FTF interview is conducted at a non-DFCS site, the facility interviewer documents the information, signs and dates the form and forwards it to DFCS.

The DFCS worker reviews the application and interview information and conducts follow-up contact with the applicant, if necessary. This follow-up can be completed by telephone.

NOTE: Applications taken by private medical facilities require a FTF interview with a DFCS eligibility worker. The application date is the date the application is received by DFCS.

PROCEDURES

Follow the steps below for applications received at approved facilities:

Step 1 Conduct a telephone interview, reviewing all point of eligibility.

EXCEPTION: Follow-up is not required for Presumptive Eligibility applications which contain all information required to determine eligibility.

Step 2 Mail required Forms DMA-285, 297A and 138.

Step 3 Determine eligibility and notify the A/R of the decision.

PROCEDURES (cont.)	
Application received for an individual currently receiving Medicaid in another state	An individual who is currently receiving Medicaid in another state but has moved to Georgia may file an application. Notify the previous state that the applicant has moved to Georgia, and approve/deny the Medicaid application. Do **not** delay the disposition of the Medicaid application while waiting for the previous state to terminate benefits. An individual may receive Medicaid in both states the month that s/he moves to Georgia.
Out-of State application for Three months Prior Medicaid for a former Georgia resident	An application may be filed for medical services received as a Georgia resident even if the individual subsequently moved out of state. Complete all necessary forms. Forms can be mailed to the applicant. A telephone interview may be conducted in lieu of a FTF interview. Determine eligibility using the appropriate Class of Assistance (COA). Refer to Section 2053, Retroactive Medicaid. If eligible, send notification of the decision and certification of Medicaid eligibility. If ineligible, send notification.
Current Georgia resident requests Three Months Prior Medicaid from another state	Refer the A/R to the previous state for application and eligibility processing. Offer assistance in contacting the other state's agency if the A/R is unable to do so.
Application for a deceased individual	Accept an application made on behalf of a deceased individual by a relative or other responsible party who can provide sufficient information for an eligibility determination. Determine eligibility based on circumstances that existed in the month(s) prior to the individual's death that Medicaid coverage is requested. Refer to Section 2053, Retroactive Medicaid. **NOTE:** The months are limited to the application month and three months prior to the application.

PROCEDURES (cont.)	
Application for a pregnant woman after the termination of pregnancy	Accept an application and determine eligibility if the A/R meets all eligibility requirements. The eligibility determination is based on actual circumstances of the month of pregnancy termination and any of the three months prior to the application month. Determine eligibility under Family Medicaid Medically Needy if the BG is over the RSM income level. **NOTE:** If eligibility is determined for any month of the pregnancy, eligibility continues through the remainder of the pregnancy and through the 60 day post-partum transition period. Refer to Section 2184, RSM Pregnant Women.
Out-of State application	Accept applications from individuals outside the state who express the intent to move to Georgia. Deny the application because the state residency is not met. Instruct the applicant to re-apply when s/he moves to Georgia.
A/R moves to another county while in application status	Complete the application process in the county in which the application was received if an applicant moves to another county prior to approval or denial of the application. Transfer an approved case to the appropriate county after eligibility is determined and the A/R is notified of the decision.
A/R is not a resident of the county in which s/he is filing an application	Inform the applicant of his/her right to file the application and explain that the application will be faxed or mailed to the county of residence AND Inform the applicant of his/her option to take the application to the county of residence him/herself. The application must be faxed or mailed by the agency the same day if the applicant requests the agency send the application. The date of application is the date the application was first filed by the applicant in any county. If the applicant chooses to take the application to the county of residence, the date of application is the date the applicant presents the application to the county of residence.

PROCEDURES (cont.)	
Applicant mails an application to a county in which s/he is not a resident	Forward the application to the county of residence. The date of application is the date the application is first received by any county in the state.
Changes While in Applicant Status	Inform the applicant that s/he is required to report within 10 days any change that occurs during the application process. Take action on the reported change during the application process, allowing the applicant sufficient time to provide any information and/or verification that may be required.

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2101 – ABD MEDICAID CLASSES OF ASSISTANCE OVERVIEW

POLICY STATEMENT

An individual must meet the requirements specified under a particular class of assistance (COA) in order to be determined eligible for ABD Medicaid.

BASIC CONSIDERATIONS

ABD Medicaid COAs are divided into the following two types:

- FBR (Federal Benefit Rate) – COAs that use the SSI FBR to determine income eligibility.
- Non FBR – COAs that use an income limit other than the FBR to determine income eligibility.

The FBR COAs consist of the following:

- SSI Medicaid
- Pickle (PL 94-566)
- Disabled Adult Child (PL 99-643)
- Disabled Widow(er) Age 50-64
- Widow(er) 60-64 (PL 100-203)
- Widow(er) 1983 (PL 99-272)
- Protected Medicaid 1972 (PL 92-603)
- Former SSI Disabled Child

The Non-FBR COAs consist of the following:

- Community Care Services Program (CCSP)
- Mental Retardation Waiver Program (MRWP)
- Deeming Waiver (Katie Beckett)
- Hospice
- Hospital
- Independent Care Waiver Program (ICWP)
- Model Waiver Program
- Laurens County Head Injury Waiver
- Nursing Home
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiaries
- Qualifying Individuals 1
- Qualifying Individuals 2
- Qualified Disabled Working Individuals (QDWI)
- ABD Medically Needy (AMN)

BASIC CONSIDERATIONS (cont.)

Refer to Chapter 2050, Application Processing, for a discussion of other Medicaid coverage, including the following:

- Emergency Medical Assistance, Section 2054
- Retroactive Medicaid, including three months prior and intervening months, Section 2053
- Sponsored Aliens, Section 2055

NOTE: QMB eligibility for persons receiving SSI only (no RSDI or RR income) is discussed in Section 2143, Qualified Medicare Beneficiaries.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under a specific COA.

Step 1 Accept the individual's ABD Medicaid application and register the application on the system.

Step 2 Screen each A/R to determine potential SSI eligibility, Family Medicaid and/or TANF eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the correct SSI trial budget to complete (Individual, Couple or Spouse to Spouse Deeming).

- Use the FBR as the income limit when completing the SSI trial budget.

Step 3 Refer the A/R to the appropriate worker if the A/R appears to be eligible for Family Medicaid and/or TANF and wishes to file an application for either.

NOTE: The A/R's application for assistance is protected.

Refer the A/R to SSA to file an SSI application if his/her Federal Countable Income (FCI) is less than the appropriate Federal Benefit Rate (FBR) unless one of the following situations exist:

- The A/R requests coverage for any of the 3 months prior to the SSI or ABD Medicaid Application Month.

- The A/R is ineligible due to the deemed income or resources of his/her spouse or parents.

PROCEDURES (cont.)

Step 3 (cont.)

- The A/R dies prior to applying for SSI.
- The A/R is ineligible for Family Medicaid/SSI due to excess resources.
- The A/R has Medicare or other insurance that is expected to pay (or pays) more than 50% of medical expenses, and the A/R is in a public or private hospital or nursing home.

NOTE: A potentially eligible SSI applicant may not elect to receive ABD Medicaid instead of SSI.

EXCEPTION: An A/R may elect to receive QMB when potentially eligible for SSI without applying for SSI.

Step 4 Conduct a face to face interview, if required by policy, to gather necessary information and request needed verification.

Step 5 Determine the COA most advantageous to the A/R.

NOTE: Explain the advantages of each COA if the A/R is potentially eligible under more than one COA and allow the A/R to choose the COA.

Step 6 Determine basic eligibility. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 7 Determine financial eligibility. Refer to PROCEDURES under the specific section on each COA.

Step 8 If the A/R is eligible under the COA currently being used to determine eligibility, approve ABD Medicaid on the system.

If the A/R is ineligible under the COA currently being used to determine eligibility, complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

2111 – SUPPLEMENTAL SECURITY INCOME (SSI) MEDICAID

POLICY STATEMENT

Supplemental Security Income (SSI) is a direct monetary payment program administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

SSI Medicaid is used as a class of assistance (COA) for determining retroactive ABD Medicaid eligibility.

BASIC CONSIDERATIONS

Georgia SSI recipients are automatically eligible for Medicaid for any month in which they receive a check except when they refuse to assign TPR. Refer to Section 2230, Third Party Resources.

To be eligible under the SSI Medicaid COA, the A/R must meet the following conditions:

- The A/R has applied for SSI or ABD Medicaid.
- The A/R requests ABD Medicaid coverage for a month(s) for which s/he is not eligible to receive a SSI payment, such as the following:
  - two months prior to a SSI approval
  - three months prior to a SSI denial
  - three months prior to an ABD Medicaid application
  - intervening months related to a SSI application for which the applicant is not financially eligible for a SSI payment
  - the months in which the income of a sponsor renders an alien ineligible for SSI.
- The A/R meets all basic and financial eligibility criteria.

NOTE: Length of Stay (LOS) and Level of Care (LOC) are **not** requirements for this COA.

Do **not** determine eligibility under the SSI COA for any month covered by a SSI application (the three prior months, the month of SSI application and ongoing) while the SSI application is pending. Refer to Section 2054, Retroactive Medicaid.

BASIC CONSIDERATIONS (cont.)

Effective for SSI applications filed on or after August 22, 1996, the first month of SSI payment is the first month following the date the application is filed, or the first month following the month the individual becomes eligible for SSI, whichever is later. For approved or denied SSI applications, the three prior months are the three months preceding the month of SSI application.

EXCEPTION: Do **not** use the SSI Medicaid COA to determine eligibility for the **third month** prior to a SSI approval. Refer to Section 2053, Retroactive Medicaid, for instructions on processing eligibility for SSI prior months.

PROCEDURES

Follow the steps below to determine Medicaid eligibility under the SSI Medicaid COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Determine all basic eligibility criteria except LOS and LOC. Refer to Section 2200, Basic Eligibility Criteria.

Step 4 Determine financial eligibility using the current SSI income and resource limits. Refer to the Section 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider.
- Which SSI income and resource limit (individual or couple) to use,
- Which eligibility budget to complete.

Step 5 Approve Medicaid on the system using the SSI Medicaid COA for any retroactive month in which the A/R meets all eligibility criteria.

NOTE: Refer to Section 2053 for the appropriate COA to use and procedures on completing prior months for SSI applications.

Approve ongoing Medicaid under the SSI Medicaid COA for sponsored aliens.

NOTE: Do **not** approve Medicaid using the SSI Medicaid COA for any month that the A/R was eligible for **and** received a SSI payment with the exception of nursing home COA.

2113 – PICKLE (PUBLIC LAW 94-566)

POLICY STATEMENT	Pickle (PL 94-566) is a class of assistance (COA) that provides for an individual or couple who correctly received RSDI and SSI or a Mandatory State Supplement (MSS) concurrently and became ineligible for SSI or MSS for any reason but is currently ineligible for SSI because of RSDI COLAs.
BASIC CONSIDERATIONS	To be eligible under the Pickle COA, the A/R must meet the following conditions: • The A/R previously and correctly received RSDI and SSI or MSS concurrently.* • The A/R's SSI or MSS was terminated after 4/77 for any reason. • The A/R is eligible for SSI or MSS if the RSDI COLAs received by the A/R and/or his/her spouse since the A/R last received SSI or MSS are disregarded. • The A/R meets all basic and financial eligibility criteria. ***EXCEPTION:** In couple situations, only one spouse needs to have received RSDI and SSI or MSS concurrently. However, each individual must have previously received SSI or MSS in order to establish eligibility under this COA. **NOTE:** Length of Stay (LOS) and Level of Care (LOC) are **not** requirements for this COA. Individuals who receive a SSI and RSDI payment in the last month of the waiting period on initial entitlement to RSDI disability benefits are **not** considered to have received SSI and RSDI concurrently.
PROCEDURES	Follow the steps below to determine Medicaid eligibility under the Pickle COA.
Step 1	Accept the A/R's Medicaid Application.
Step 2	Conduct a face-to-face interview.
Step 3	Obtain verification from SSA to verify the following: • The date SSI benefits were terminated. • The current amount of the A/R's and/or his/her spouse's RSDI. • The amounts of all RSDI COLAs the A/R and/or his/her spouse have received since SSI was terminated.

PROCEDURES (cont.)

Step 4 Obtain verification from SSA to verify the following:

- The date SSI benefits were terminated.
- The current amount of the A/R's and/or his/her spouse's RSDI.
- The amounts of all RSDI COLAs the A/R and/or his/her spouse have received since SSI was terminated.

Step 5 Determine all basic eligibility criteria except LOS and LOC. Refer to Section 2200, Basic Eligibility Criteria.

Determine all basic eligibility using the current SSI income and resource limits. Refer to Section 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider.
- Which SSI income and resource limit (individual or couple) to use
- Which eligibility budget to complete.

Step 6 Determine the A/R's countable income by disregarding the following amounts of RSDI income.

- The COLA that caused SSI termination

OR

The first COLA received after SSI was terminated for a reason other than receipt of a COLA, such as a resource ineligibility

AND

- All subsequent COLAs.

NOTE: The COLAs of the A/R (individual or couple) and the A/R's ineligible spouse can be disregarded in determining eligibility under the Pickle COA.

Step 7 Approve Medicaid on the system using the Pickle COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

NOTE: Do **not** approve Medicaid using the Pickle COA for any month for which the A/R was eligible for and received a SSI payment.

2115 – DISABLED ADULT CHILD (PUBLIC LAW 99-643)

POLICY STATEMENT	Disabled Adult Child (PL 99-643) is a class of assistance (COA) that provides Medicaid for an individual age 18 or over who had his/her SSI terminated on or after 7/1/87 because of entitlement to or an increase in RSDI income received as a disabled adult child.
BASIC CONSIDERATIONS	To be eligible under the Disabled Adult Child COA, the A/R must meet the following conditions: • The A/R is currently receiving RSDI as a disabled adult child. • The A/R previously received SSI that was terminated on or after 7/1/87 because of an increase in or initial entitlement to RSDI as a disabled adult child. • The A/R is eligible for SSI if the initial entitlement to RSDI, an increase in RSDI and/or RSDI COLAs received since the A/R last received SSI are disregarded. • The A/R meets all basic and financial eligibility criteria. **NOTE:** Length of Stay (LOS) and Level of Care (LOC) are **not** requirements for this COA.
PROCEDURES	Follow the steps below to determine Medicaid eligibility under the Disabled Adult Child COA.
Step 1	Accept the A/R's Medicaid application.
Step 2	Conduct a face-to-face interview.
Step 3	Obtain verification from SSA to verify the following: • The date SSI benefits were terminated. • The current amount of the A/R's RSDI disabled adult child benefit. • The amounts of the RSDI initial entitlement, increase or COLA that caused SSI termination and all COLAs received since SSI was terminated.
Step 4	Determine all basic eligibility criteria except LOS and LOC. Refer to Chapter 2200, Basic Eligibility Criteria.
Step 5	Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following: • Whose income and resources to consider • Which SSI income and resource limit (individual or couple) to use • Which eligibility budget to complete.

PROCEDURES (cont.)

Step 6

- Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The initial entitlement to or increase in RSDI as a disabled adult child or an increase in RSDI income that caused SSI termination

OR

- The RSDI disabled adult child COLA that caused SSI termination

AND

- All subsequent COLAs.

NOTE: The RSDI claim number will end with a beneficiary identification code (BIC) that includes **C** if the A/R receives RSDI as a disabled adult child.

Step 7

Approve Medicaid on the system using the Disabled Adult child COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

NOTE: Do **not** approve Medicaid using the Disabled Adult Child COA for any month for which the A/R was eligible for and received a SSI payment.

2116 – FORMER SSI-DISABLED CHILD

POLICY STATEMENT

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed the definition of disability for children. As a result, a number of children were terminated from SSI. The Balanced budget Act of 1997 mandated that for any child who became ineligible for SSI due to the new definition of disability, the State must redetermine Medicaid eligibility using the previous definition of disability. The Act further specified that the disability status of the child must be protected as long as the child remains eligible for SSI but for the change in definition of disability.

BASIC CONSIDERATIONS

To be eligible under the Former SSI-Disabled Child COA, the A/R must meet the following conditions:

- The A/R was receiving SSI as a disabled child on August 22, 1996, and was terminated as a result of SSA's new definition of disability. This includes those SSI A/R's who, as of August 22, 1996:
  - were in current pay status; or
  - received a favorable or partially favorable administrative decision from SSA; or
  - were terminated due to non-cooperation with the disability redetermination process of SSA; or
  - had a Zebley appeal pending.
- Th A/R would be eligible for SSI but for the passage of the new disability decision.
- The A/R continues to meet all basic and financial eligibility criteria for SSI.

NOTE: Length of Stay (LOS) and Level of Care (LOC) are **not** requirements for this COA.

PROCEDURES

Follow the steps below to determine Medicaid eligibility under the Former SSI-Disabled Child COA:

Step 1 Use the DMA generated report entitled SSI to Disabled Children (Section 4913) **or** accept an application from any A/R contacting DFCS whose name did not appear on said report. Refer to Section 2752, Continuing Medicaid Determination Reports, for instructions on processing the report.

PROCEDURES (cont.)

Step 2 Screen the A/R in the system to determine if they have an active Medicaid case with DFCS.

Step 3 For A/R's not appearing on the SSI to Disabled Children (Section 4913) Report, verify that the child was receiving SSI on August 22, 1996, and that the SSI was terminated due to the new definition of disability. For children whose names do appear on the report, accept the report as verification for this step.

Step 4 Using SDX, BENDEX and any other available information, register the case on the system. Prior receipt of SSI is prima facie evidence of disability until the first annual review for all A/R's who were terminated SSI as a result of the new disability decision.

Step 5 Approve Medicaid, including retroactive months if requested, on the system within 10 days of receipt of the list or application unless available information determines the A/R to be ineligible.

If the A/R is ineligible, see SPECIAL CONSIDERATIONS below. Notify DMA via the form on the GoMail bulletin board entitled *Medicaid Forms* if the A/R is ineligible for any COA.

Ongoing Eligibility The county must complete a full review of eligibility within 12 months of approval or when a change is reported, whichever is earlier.

At the first review of eligibility, submit a disability request to SMEU, specifying that the A/R is a Former SSI-Disabled Child. Redetermine all other points of eligibility using **current** SSI eligibility criteria in order to establish continued ongoing eligibility.

SPECIAL CONSIDERATIONS

If the A/R was terminated for SSI for any reason other than disability, the A/R is **NOT** eligible for Medicaid under this COA. Complete a CMD. Refer for TANF or Family Medicaid if appropriate. Only request an SMEU decision for another ABD COA if the SSI has been terminated for more than 12 months

If an A/R is approved for but later becomes ineligible for Medicaid under the Former SSI-Disabled child COA for any reason other than disability, the child's disability status remains protected. The child **can** become eligible again under this COA.

2117 – DISABLED WIDOW(ER)

POLICY STATEMENT	The Disabled Widow(er) class of assistance (COA) Provides Medicaid for an individual whose SSI was terminated because of his/her entitlement to an RSDI disabled widow(er) benefit.
BASIC CONSIDERATIONS	To be eligible under the Disabled Widow(er) COA the A/R must meet the following conditions: • The A/R is a disabled widow(er) or a disabled surviving divorced spouse between the ages of 50-64. • The A/R is currently receiving RSDI as a disabled widow(er)/disabled surviving divorced spouse. • The A/R is currently ineligible for Medicare Part A coverage. • The A/R previously received SSI or a Mandatory State Supplement (MSS) that was terminated on or after 1/1/91 because of his/her initial entitlement to RSDI as a disabled widow(er)/disabled surviving divorced spouse. • The A/R is eligible for SSI or MSS if the initial entitlement to RSDI as a disabled widow(er) and all subsequent COLAs are disregarded. • The A/R meets all basic and financial eligibility criteria. **NOTE:** Length of Stay (LOS) and Level of Care (LOC) are **NOT** requirements for this COA. A disabled Widow(er) is an individual who applies for RSDI between the ages of 50-59 and is determined to meet RSDI disability criteria. A widow(er) who applies for RSDI at age 60 or older can receive RSDI without meeting disability requirements. SSA will accept a disability application on these individuals after age 60 only for the purpose of establishing Medicare entitlement. These individuals are not eligible for Medicaid under the Disabled Widow(er) COA. Consider eligibility under the Widow(er) Age 60 to 64 COA. **NOTE:** Disabled widow(er)s whose SSI was terminated on or after 1/1/91 are allowed to count previous months of SSI eligibility toward the 24 month waiting period for Medicare entitlement.

PROCEDURES

Follow the steps below to determine Medicaid eligibility under the Disabled Widow(er) COA:

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Obtain verification from the SSA to verify the following:

- The date SSI/MSS benefits were terminated
- The current amount of the A/R's RSDI Disabled Widow(er) benefit
- The amounts of the RSDI initial entitlement that caused SSI/MSS termination and all COLAs received since SSI/MSS was terminated.
- The A/R's current ineligibility for Medicare Part A coverage.

Step 4 Determine all basic eligibility criteria except LOS and LOC. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider
- Which SSI income and resource limit (individual or couple) to use
- Which eligibility budget to complete

Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The initial entitlement to RSDI as a disabled widow(er) that caused SSI termination

AND

- All subsequent COLAs

NOTE: The RSDI claim number will end with a beneficiary identification code (BIC) that includes "W" if the A/R receives RSDI as a disabled widow(er) or surviving divorced spouse.

PROCEDURES (cont.)

Step 6 Approve Medicaid on the system using the Disabled Widow(er) COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

NOTE: Do NOT approve Medicaid using the Disabled Widow(er) COA for any month for which the A/R was eligible for and received a SSI payment.

Step 7 Terminate Medicaid under this COA as soon as the A/R becomes entitled to Medicare Part A. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

2119 – DISABLED WIDOW(ER) AGE 60–64 (PUBLIC LAW 100-203)

POLICY STATEMENT

Widow(er) Age 60 – 64 (PL 100-203) is a class of assistance (COA) that provides Medicaid for a widow(er) who applies for an RSDI widow(er) benefit at age 60 or older and subsequently has his/her SSI terminated because of his/her entitlement to an RSDI widow(er) benefit.

BASIC CONSIDERATIONS

To be eligible under the Widow(er) Age 60–64 COA the A/R must meet the following conditions:

- The A/R is a disabled or blind widow(er) aged 60 – 64.
- The A/R is currently receiving an RSDI widow(er)/surviving divorced spouse benefit.
- The A/R is currently ineligible for Medicare Part A coverage.
- The A/R previously received SSI that was terminated because of his/her initial entitlement to RSDI as a widow(er)/surviving divorced spouse.
- The A/R is eligible for SSI if the initial entitlement to RSDI as a widow(er)/surviving divorced spouse and all subsequent COLAs are disregarded.
- The A/R meets all basic and financial eligibility criteria.

NOTE: Length of Stay (LOS) and Level of Care (LOC) are **NOT** requirements for this COA.

When the A/R becomes Medicare eligible at age 65 or after 24 months as disabled, s/he is NO longer eligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

Refer to Section 2117, Disabled Widow(er), for information on Medicare entitlement based on disability for an individual receiving an RSDI widow(er) benefit.

PROCEDURES

Follow the steps below to determine Medicaid eligibility under the Widow(er) Age 60 – 64 COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Verify that the A/R is age 60 – 64.

PROCEDURES (cont.)

Step 4 Obtain verification from the SSA to verify the following:

- The date SSI benefits were terminated.
- The current amount of the A/R's RSDI Widow(er) benefit.
- The amounts of the RSDI initial entitlement that caused SSI termination and all COLAs received since SSI was terminated
- The A/R's current ineligibility for Medicare Part A coverage.

Step 5 Determine all basic eligibility criteria except LOS and LOC. Refer to Chapter 2200, Basic Eligibility Criteria.

NOTE: Verify blindness or disability if the A/R does not have prima facie evidence of blindness or disability, such as receipt of an RSDI disability benefit. Refer to Section 2205, ABD Requirement.

Step 6 Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider.
- Which SSI income and resource limit (individual or couple) to use.
- Which eligibility budget to complete.

Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The initial entitlement to RSDI as a widow(er) that caused SSI termination

AND

- All subsequent COLAs.

NOTE: The RSDI claim number will end with a beneficiary identification code (BIC) that includes "D" if the A/R receives RSDI as a widow(er)/surviving divorced spouse.

PROCEDURES (cont.)

Step 7 Approve Medicaid on the System using the Widow(er) Age 60-64 COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

NOTE: Do NOT approve Medicaid using the Widow(er) Age 60-64 COA for any month for which the A/R was eligible for and received a SSI payment.

Step 8 Terminate Medicaid under this COA as soon as the A/R becomes entitled to Medicare Part A. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

2121 – WIDOW(ER) 1984 (PUBLIC LAW 99-272)

POLICY STATEMENT	Widow(er) 1984 (PL 99-272) is a class of assistance (COA) for an individual who received RSDI and SSI concurrently and became ineligible for SSI due to an adjustment in his/her RSDI disabled widow(er)'s benefit effective 1/84.
BASIC CONSIDERATIONS	**NOTE:** Do NOT determine initial ABD Medicaid eligibility under the Widow(er) 1984 COA on any application filed on or after 7/1/88. Complete annual reviews for continued eligibility on established cases as for any other COA. To be eligible under the Widow(er) 1984 COA the A/R must meet the following conditions: • The A/R received RSDI and SSI in 12/83. • The A/R became entitled to and received an adjustment in his/her RSDI disabled widow(er)'s benefit effective 1/84 that caused SSI termination in the month the increased benefit was actually received. • The A/R was continuously entitled to the increased RSDI benefit from 1/84 until the increase was actually received. • The A/R is eligible for SSI if the 1/84 increase in the RSDI disabled widow(er) benefit and any subsequent COLAs are disregarded. • The A/R meets all basic and financial eligibility criteria. **NOTE:** Length of Stay (LOS) and Level of Care (LOC) are NOT requirements for this COA.
PROCEDURES	Complete an annual review of eligibility for individuals currently eligible under the Widower 1984 COA. Refer to Section 2705, Reviews. Use the following guidelines for completing the review: Obtain verification from the SSA to verify the following: • The A/R's receipt of RSDI and SSI in 12/83. • The A/R's receipt of an increased RSDI disabled widow(er)'s benefit effective 1/84. • The A/R's ineligibility for SSI the month increased benefit was actually received. • The A/R's continuous receipt of an RSDI disabled widow(er)'s benefit. • The current amount of the RSDI widow(er)'s benefit and all subsequent COLAs.

PROCEDURES (cont.)

Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider.
- Which SSI income and resource limit (individual or couple) to use.
- Which eligibility budget to complete.

Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The 1/84 increase in the RSDI disabled widow(er)'s benefit.
- All subsequent COLAs.

NOTE: The RSDI claim number will end with a beneficiary identification code (BIC) that includes "W" if the A/R receives RSDI as a disabled widow(er)/disabled surviving divorced spouse.

NOTE: Do NOT approved Medicaid using the Widow(er) 1984 COA for any month for which the A/R was eligible for and received a SSI payment.

2123 – PROTECTED MEDICAID 1972 (PUBLIC LAW 92-603)

POLICY STATEMENT

Protected Medicaid 1972 (PL 92-603) is a class of assistance (COA) that provides Medicaid for an individual/couple who received AABD or AFDC and RSDI concurrently in 1972 and became ineligible for AABD or AFDC because of the 20% 1972 COLA increase in RSDI.

BASIC CONSIDERATIONS

To be eligible under the Protected Medicaid 1972 COA an A/R must meet the following conditions:

- The A/R is currently receiving RSDI.
- The A/R received AABD or AFDC and RSDI in 8/72.
- The A/R is currently eligible for SSI if the 1972 RSDI COLA is disregarded.
- The A/R meets all basic and financial eligibility criteria.

NOTE: Length of Stay (LOS) and Level of Care (LOC) are **NOT** requirements for this COA.

NOTE: Prior receipt of SSI is **NOT** a requirement for this COA.

PROCEDURES

Follow the steps below to determine Medicaid eligibility under the Protected Medicaid 1972 COA:

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Determine whether the A/R received AABD or AFDC in 8/72 using county and state records.

Step 4 Obtain verification from the SSA to verify the following:

- The current amount of the A/R's RSDI benefit.
- The amount of the A/R's 8/72 RSDI COLA.

Step 5 Determine all basic eligibility criteria except LOS and LOC. Refer to the Chapter 2200, Basic Eligibility Criteria.

PROCEDURES (cont.)

Step 6 Determine financial eligibility using the current SSI income and resource limits. Refer to the Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider
- Which SSI income and resource limit (individual or couple) to use
- Which eligibility budget to complete

Step 7 Approved Medicaid on the system using the Protected Medicaid 1972 COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

NOTE: Do not approve Medicaid using the Protected Medicaid 1972 COA for any month for which the A/R was eligible for and received a SSI payment.

2131 - COMMUNITY CARE SERVICES PROGRAM

POLICY STATEMENT

Community Care Services Program (CCSP) is a class of assistance (COA) designed to provide in home and community based services to individuals. These individuals meet the criteria for nursing home placement but choose to remain in a residential home situation.

BASIC CONSIDERATIONS

To be eligible under the CCSP COA an A/R must meet the following conditions:

- The A/R is placed in a CCSP slot and is receiving waivered service(s).
- The A/R resides in a residential home situation, such as his/her own home, another person's home or a personal care home.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

NOTE: There are no age requirements for participation in CCSP. A client is not required to be homebound to receive CCSP services.

CCSP Medicaid recipients receive certain *waivered* services not normally covered by Medicaid, including the following:

- Adult Day Rehabilitation
- Alternate Living Services (personal care home placement)
- Emergency Response System
- Home Delivered Services
- Homemaker Aid
- Respite Care.

NOTE: To maintain continuous eligibility for CCSP Medicaid, a client must receive a waivered service each calendar month.

Individuals who express an interest in Community Care services should be referred to the Community Care Assessment Team (AT) for their Agency Area on Aging (AAA). The AT assesses the individual's suitability for community based care in lieu of nursing home placement and initiates completion of Form 5588 to obtain a LOC.

BASIC CONSIDERATIONS (cont.)

CCSP is limited to a certain number of *slots* statewide.

- The individual determined suitable by the AT for community care is placed under the case management of a CCSP care coordinator as soon as a slot becomes available.

- The care coordinator arranges for the provision of the CCSP waivered services to the recipient.

NOTE: The date the first waivered service is provided to the CCSP recipient is the slot date.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the CCSP COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Verify that the A/R is under CCSP case management and receiving waivered service(s) by receipt of the Community Care Communicator, Form 5590. The Form 5590 should indicate the beginning date of case management date and the slot date.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to the **Chapter 2200, Basic Eligibility Criteria**.

Step 5 Determine financial eligibility.

- See **Chapter 2500, ABD Financial Responsibility and Budgeting**, for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to the **Section 2510, Medicaid CAP Budgeting**.

Step 6 Determine the A/R's cost share for CCSP services. Refer to the **Chapter 2559, Patient Liability/Cost Share.**

PROCEDURES (cont.)

Step 7 Approve Medicaid on the system using the CCSP COA if the A/R meets all the above eligibility criteria.

NOTE: DO NOT approve Medicaid under the CCSP class of assistance for any month earlier than the month of the slot date.

Step 8 Notify the A/R of case disposition and cost share via the system.

Step 9 Notify the care coordinator of the disposition and cost share on Form 5590 (CCC) or by entering the care coordinator's name and address in the system as the Authorized Representative. This will enable the care coordinator to receive system generated notices giving dates of eligibility and cost share information.

Step 10 Complete a review of the case in the month in which the CCSP stay expires as indicated in Field 41, L.O.S, of Form 5588.

- If a new Form 5588 extending the stay is received from the CCSP care coordinator, continue Medicaid eligibility under the CCSP COA.

- If a Form 5590 stating that the stay has **NOT** been extended is received from the care coordinator OR a new Form 5588 is not received from the CCSP care coordinator by the end of the month the stay expires, complete a CMD. Refer to the **Section 2052, Continuing Medicaid Determination**. Notify the CCSP care coordinator of the outcome of the CMD and any change in cost share.

NOTE: If Form 5588 or 5590 is not received by 2 weeks from the end of the approved CCSP stay, send a Form 5590 to the care coordinator requesting information on whether the stay has been extended.

NOTE: If Medicaid eligibility is terminated as a result of the CMD and a new Form 5588 is subsequently received within 30 days of the termination date on the system, reopen the case as closed in error. If a new Form 5588 is received more than 30 days after the system termination date, process a new application. The month the new Form 5588 is signed is the **earliest** month for which the case can be reopened under the CCSP COA.

2132 – MENTAL RETARDATION WAIVER PROGRAM AND COMMUNITY HABILITATION SUPPORT SERVICES

POLICY STATEMENT

Mental Retardation Waiver Program (MRWP)/ Community Habilitation Support Services (CHSS) are classes of assistance (COA) designed to provide in-home and community based services to Medicaid eligible mentally retarded and developmentally disabled individuals who do not receive Medicaid benefits under a cash assistance program.

BASIC CONSIDERATIONS

To be eligible under the MRWP/CHSS COA, an A/R must meet the following conditions:

- The A/R is approved by the Comprehensive Evaluation Team (CET) for the MRWP/CHSS.
- The A/R is placed in a MRWP/CHSS slot and is receiving MRWP/CHSS waivered services.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

MRWP/CHSS Medicaid recipients receive certain *waivered* services, including the following:

- Service Coordination (Case Management)
- Day Habilitation
- Residential Training and Supervision
- Supported Employment
- Home Health Services
- Respite Care
- Personal Support Services
- Environmental Modifications
- Vehicle Adaptations
- Specialized Medical Equipment and Supplies
- Community Habilitation and Support

The individual determined suitable by the CET for MRWP/CHSS is placed under the service coordination (case management) of a MRWP/CHSS provider (case manager).

The case manager arranges for the provision of waivered services to the recipient.

BASIC CONSIDERATIONS (cont.)	**NOTE:** The beginning date of service coordination (case management) is the same as the **enrollment date** for an A/R leaving an institution, and the same as the **date services begin** for an A/R already residing in the community.
PROCEDURES	Follow the steps below to determine ABD Medicaid eligibility under the MRWP/CHSS COA.
Step 1	Accept the A/R's application, the Form 1008, MRWP/CHSS Communicator, and approved DMA-6 from the CET. **NOTE:** A new DMA-6 is required upon entry into MRWP/CHSS.
Step 2	If the A/R is institutionalized or resides in the community, and is ABD Medicaid eligible, schedule a review and face-to-face contact when contacted by the CET. Proceed to Step 6.
Step 3	If the A/R is institutionalized or resides in the community, and is not currently eligible for Medicaid, schedule an initial interview when contacted by the CET.
Step 4	Determine basic eligibility. Refer to Chapter 2200, Basic Eligibility Criteria.
Step 5	Determine financial eligibility. • Refer to Chapter 2500, ABD Financial Responsibility and Budgeting. • Complete a Medicaid Cap Budget to determine income eligibility. Refer to Section 2510, Medicaid Cap Budgeting.
Step 6	Determine if the Length of Stay criteria is met. Refer to Section 2235, Length of Stay.
Step 7	The system will determine the A/R's Cost Share for MRWP/CHSS services. Refer to Chapter 2559, Patient Liability/Cost Share. The PNA is the same amount as the Medicaid Cap.
Step 8	Approve on the system if the A/R meets all eligibility criteria. **NOTE:** Do not approve Medicaid under the MRWP/CHSS COA for any month prior to the month of either the MRWP/CHSS Enrollment Date or Date Services Begin listed on Form 1008, MRWP/CHSS Communicator or prior to 2/1/94, the effective date of the MRWP, or 10/1/97, the effective date of the CHSS amendment.

PROCEDURES (cont.)

Step 9 Complete Section III of Form 1008, MRWP/CHSS Communicator. Enter the Medicaid number at the top of the form. Send to the originating CET with a copy to the Regional Board (as noted on Form 1008). A list of Regional Board addresses and the counties they serve is found at the end of Section 2135). The CET will complete the return address for the CET and the Regional Board. File a copy in the case record.

Step 10 Notify the A/R of case disposition via the system.

SPECIAL CONSIDERATIONS

The MRWP/CHSS COA requires one specifically designated form:

- Form 1008, MRWP/CHSS Communicator

The MRWP/CHSS Communicator functions much like the Community Care Communicator (CCC). The form is initiated by the CET. The CET completes the following sections:

- The top section, with all identifying information except the Medicaid number, unless the A/R is already a Medicaid recipient.
- Section I
- Section II, giving the discharge date and enrollment date, or the date services begin, and a request for determination of Medicaid eligibility (if needed).
- Section V, giving the date the A/R was institutionalized. The date the A/R was institutionalized is necessary to determine if Length of Stay has been met.

The Form 1008 Communicator must be reproduced locally. A copy of Form 1008 is found at the end of Section 2132.

Georgia Department of Human Resources
MENTAL RETARDATION WAIVER PROGRAMS COMMUNICATOR
MAO DETERMINATION (for MRWP or CHSS Waivers)

Client Name _____ County of Residence _____ MHID # _____

Address _____ Social Security # _____ Medicaid # _____

City _____ Sate _____ Zip Code _____ Date of Birth _____ (Area code) Phone # _____

SECTION I COMPLETED BY CET CASEMANAGER

_____ Date client was determined eligible for the Medicaid Waiver program (MRWP) or Community Habilitation and Support Services Waiver (CHSS)

Signature _____ Phone #: _____ Date: _____

SECTION II : COMPLETED BY MRWP/CHSS/CET CASE MANGER (check those that apply)

_____ Client currently resides in an ICF-MR, which received Medicaid reimbursement. Please compute cost share.
_____ Client currently resides in the community and does not receive Medicaid. Please determine eligibility and cost share. Date services began: _____
_____ Client is currently receiving MAO. Please compute cost share.
_____ Client needs annual redetermination of MAO status and cost share.
_____ Client requires a home visit application (Reason in remarks).

Signature _____ Phone #: _____ Date: _____

SECTION III: COMPLETED BY DFACS WORKER

_____ Date client applied for MAO ELIGIBILITY DATE: _____

$ _____ Client Cost Share Effective Date: _____

$ _____ Client cost share due to liability change Effective date: _____

_____ Date client was determined INELIGIBLE (Reason in Remarks)

Signature _____ Phone #: _____ Date: _____

SECTION 1V COMPLETED BY MRWP/CHSS CASEMANAGER

This client has been released from the MRWP/CHSS effective _____, for the following reason:

_____

Signature _____ Phone #: _____ Date: _____

SECTION V COMPLETED BY MRWP/CHSS CASE MANAGER OR DFACS WORKER

Remarks: _____

_____

Return to: CET (address) _____

Regional Board (address) _____

(CET TO COMPLETE ADDRESS INFORMATION)

COMMUNITY SERVICE BOARDS (CSBs) By Region

Revised April 12,2000

Region	Counties in Service Area	CSB Name	Director	Address and Telephone Number
1 Alan L. Ziglin, Ph.D. Director 32 West Main Street Suite 104 Cartersville, GA 30120 Phone 770-387-5411 FAX 770-387-5417 Board Chair: Jim Carden Secretary: Delana Tidwell Utilization Mgr: Raymer Wilson Program & Svcs Coor: Maelene Pritchett ASM: Brenda Hester Prevention Spec: John Lauken Cons. Prot/Pl Coor: Cheryl Brimage	Walker Dade Catoosa Chattooga	Lookout Mountain Community Services	Tom Ford, Ph.D.	P.O. Box 1027 LaFayette, GA 30728-1027 Telephone: (706) 638-5584 FAX: (706) 638-5585
	Floyd Gordon Bartow Polk Paulding	Three Rivers Behavioral Health Services	Tom Joiner	43 Chateau Court, S.E. Rome, Georgia 30161-7238 Telephone: (706) 802-5600 FAX (706) 295-6664
	Whitfield Murray Fannin Gilmer Pickens Cherokee	Georgia Highlands Community Service Board	James Baird	1401 Burleyson Street Dalton, GA 30720-2566 Telephone: (706) 270-5000 FAX (706) 270-5111
	Haralson	Haralson County Center for MH/MR/SA	Stephen L. Helton	217 Tennessee Avenue Bremen, Georgia 30110-2153 Telephone: (770) 537-2367 FAX (770) 537-1203
2 Donald K. Simpson Director 14 Amlajack Boulevard, #2 Newnan, GA 30265 Phone 770-254-7474 FAX (770) 254-7479 Board Chair: Dr. William Nesbit Secretary: Renee Parkman Utilization Mgr: Frances Hale ASM: Olivia Sumbry Prevention Spec: Clarise M. Jackson Consumer Specialist: Michael J. Shaw Cons. Prot/Pl Coor: Will Grimes	Clayton	Clayton Community MH, SA Developmental Services Board	Jimmy Wiggins, Acting	112 Broad Street Jonesboro, GA 30236-1919 Telephone: (770) 478-2280 FAX: (770) 477-9772
	Troup Carroll Heard Coweta Meriwether	Pathways Center for Behavioral and Developmental Growth	Joan Moore	120 Gordon Commercial Drive, Suite A LaGrange, GA 30240-5740 Telephone: (706) 845-4045 FAX (706) 845-4341
2 (Continued) Donald K. Simpson	Spalding Fayette Henry	McIntosh Trail Community Service Board	Cathy Johnson	P. O. Box 1320 Griffin, GA 30224 Telephone: (770) 358-5252

Region	Counties in Service Area	CSB Name	Director	Address and Telephone Number
Director	Butts Pike Lamar Upson			FAX (770) 229-3223
3 Margaret Bradford Director 236 Industrial Park Drive Commerce, GA 30529 Phone 706-336-6822 FAX 706-335-5240 Board Chair: Larry Miller Secretary: Julie West Utilization Mgr: Frances Gamsey-Borman ASM: Benjie Wood Prevention Spec: Melissa Gindlesperger Cons. Prot/PI Coor: Mattee Santosha	Hall Union Towns Rabun White Habersham Stephens Lumpkin Dawson Forsyth Banks Franklin Hart	Georgia Mountains Community Services	Boyd McLocklin	P.O. Box 1317 Gainesville, GA 30503-1317 Telephone: (770) 535-5403 or 800-525-8751 800-347-5827 (Emergency and Night Number) FAX 770-531-6006
	Clarke Jackson Barrow Walton Madison Oconee Morgan Elbert Oglethorpe Greene	Northeast Georgia Center Community Service Board	Stephen Foti	250 North Avenue Athens, GA 30601-2244 Telephone: (706) 542-9739 FAX 706-542-9739
4 C. Annette Maxey Director 2137 Kingston Court, S.E. Suite 108 Marietta, GA 30067 Phone 770-916-2100 FAX 770-916-2102 Board Chair: Harry Silvis Secretary: Debra Sheriff Utilization Mgr: Sharon Williams-Mack ASM: Charles Davis Prevention Spec: Clariece Morris Cons. Prot/PI Coor: Susan Hopkins	Cobb	Cobb County Community Services Board	Tod Citron	361 N. Marietta Parkway Suite 200 Marietta, GA 30060-1400 Telephone: (770) 429-5000 FAX 770-528-9824
	Douglas	Douglas County Community Services Board	Tod Citron	361 N. Marietta Parkway Suite 200 Marietta, GA 30060-1400 Telephone: (770) 429-5000 FAX 770-528-9824
5 Earnestine Pittman	Fulton	Fulton County Community Service Board	Bruce Albert, Interim Director	141 Pryor Street S.W. Suite 4035

Region	Counties in Service Area	CSB Name	Director	Address and Telephone Number
Director Citizens Trust Building 75 Piedmont Ave, 11th Floor Atlanta, GA 30303 Phone 404-463-6367 FAX 404-463-6369 Board Chair: Peggy Farris Secretary: Ivory Roberson MH Utilization Mgr: Lynn Copeland MR Utilization Mgr.: Gloria Sheppard MR Secretary: Sarah Alexander ASM: Berle Winston Prevention Spec: Doris Thomas Cons. Prot/PI Coor: Noel Fannell				Atlanta, GA 30303-3402 Telephone: - (404) 730-0210 FAX 404-730-0245
6 Carol T. Bush, Ph.D. Director 4329 Memorial Drive Suite K Decatur, GA 30032 Phone 404-298-4990 FAX 404-298-4994 Board Chair: Sandra Rice Secretary: Vacant Utilization Mgr: Phillip Harshaw ASM: Beverly Rollins Prevention Spec: Gloria Leslie Cons. Prot/PI Coor: Patricia King	DeKalb	DeKalb Community Service Board	R. Derril Gay, Ph.D.	445 Winn Way Room 464 Decatur, GA 30030-1707 or P. O. Box 1648 Decatur, GA 30032 Telephone (404) 294-3836 (Switchboard) 294-3834 FAX 404-508-7795
7 James Mallory Director 1987 Scenic Highway SW Suite 201 Snellville, GA 30078 Phone 770-972-6305 FAX 770-972-0324 Board Chair: Daryl Myers Secretary: Helen Chandler Utilization Mgr: Carmen Watkins ASM: David Vaughn Prevention Spec: Ray Avant Cons. Prot/PI Coor: David Leigh	Gwinnett Rockdale Newton	GRN Community Service Board	Bobby Robbins	P.O. Box 687 Lawrenceville, GA 30046-0687 Telephone: (770) 339-5019 FAX 770-339-5382
8	Laurens	Community Service Board of Middle	Patsy Thomas, Ed.D.	2121 A Bellevue Road

Region	Counties in Service Area	CSB Name	Director	Address and Telephone Number
Beth Tyler, Interim Director 515 Academy Avenue Dublin, GA 31021 Phone 912-274-7912 FAX 912-274-7915 Board Chair: Walker McKnight Secretary: Emily Killingsworth Utilization Mgr: Jennifer Freeman ASM: Beth Tyler Prevention Spec: Debbie Newman Cons. Prot/Pt Coor: Lynne Tolison	Johnson Bleckley Pulaski Wilcox Dodge Telfair Wheeler Montgomery Treutlin	Georgia		Dublin, GA 31021-2998 Telephone: (912) 272-1190 FAX 912-275-6509
	Bibb Monroe Jones Twiggs	River Edge Behavioral Health Center	Frank Fields	175 Emery Highway Macon, GA 31217-3692 Telephone: (912) 751-4515 FAX 912-752-1040
	Houston Crawford Peach	Phoenix Center Behavioral Health Services	Don Blair	P.O. Box 2866 Warner Robins, GA 31099-2866 Telephone: (912) 322-4058 Director's Phone: (912) 322-4059 FAX 912-322-4085
	Baldwin Jasper Putnam Hancock Washington Wilkinson	Oconee Community Service Board	John Prather	P.O. Box 1827 Milledgeville, GA 31061-1827 Telephone: (912) 445-4817 FAX 912-445-4963
9 Gregory C. Hoyt Director c/o West Central GA Regional Hospital P. O. Box 12435 Columbus, GA 31917 Phone 706-568-5281 FAX 706-569-3140 Board Chair: Michael Johnson Secretary: Martha Gayles Utilization Mgr: Linda Heard ASM: Rick Valentine CSB Prevention Spec: Charlotte Billups	Muscogee Harris Talbot Chattahoochee Stewart Quitman Randolph Clay	New Horizons Community Services Board	Perry Alexander	P.O. Box 5328 Columbus, GA 31906-0328 Telephone: (706) 596-5583 FAX 706-596-5589

Region	Counties in Service Area	CSB Name	Director	Address and Telephone Number
	Sumter Webster Marion Taylor Schley Macon Dooly Crisp	Middle Flint Behavioral HealthCare	Pam Davis	P.O. Drawer 1348 Americus, GA 31709-1348 Telephone: (912) 931-2470 FAX 912-931-2474
10 Kenneth Brandon Director 507 Third Avenue Suite 4 Albany, GA 31701 Phone 912-430-3017 FAX 912-430-4098 Board Chair: Robert C. Sise Secretary: Anita Alexander Utilization Mgr: Katrina Green ASM: Lennard Thompson Prevention Spec: Andre' Marria Cons. Prof/PI Coor: Natalie Smith	Dougherty Terrell Lee Calhoun Worth Early Miller Baker	Albany Area Community Service Board	John Burns, Ed.D.	P.O. Box 1988 Albany, GA 31702-1988 Telephone: (912) 430-4042 FAX 912-430-4047
	Thomas Mitchell Colquitt Seminole Decatur Grady	The Georgia Pines Community MHMRSA Services	Robert Jones	1102 Smith Avenue, Suite K P. O. Box 1659 - Zip 31799 Thomasville, GA 31792-1659 Telephone: (912) 225-4370 FAX 912-225-4374
11 Catherine McRae Director 211 E. Ashley Street Suie 104&105 P. O. Box 1250 Douglas, GA 31534 Phone 912-389-4207 FAX 912-389-4074 Board Chair: Tony Batten Secretary: Patricia Bratcher Utilization Mgr: Tara Phillips ASM: Patricia Wright Prevention Spec: Joe Troope Cons. Prof/PI Coor: Carla Linkous	Lowndes Turner Ben Hill Irwin Tift Berrien Cook Brooks Lanier Echols	Behavioral Health Services of South Georgia	David McCracken	P.O. Box 3318 Valdosta, GA 31604-3318 Telephone: (912) 333-7095 FAX 912-333-7093

Region	Counties in Service Area	CSB Name	Director	Address and Telephone Number
	Ware Coffee Bacon Atkinson Pierce Brantley Clinch Charlton	Satilla Community Service Board for MH, MR and SA	Dennis Wool, Ph.D.	P.O. Box 1397 Waycross, GA 31502-1397 Telephone: (912) 284-2543 FAX 912-287-6660
12 M. Andrew McCollum Director 1056 Claussen Road Suite 223 Augusta, GA 30907 Phone 706-667-4833 FAX 706-667-4849 Board Chair: Andy Lloyd, Ph.D. Secretary: Betsy Capers Utilization Mgr: Betty Dyches ASM: Larry Howell Prevention Spec: Jennifer Gorman Cons. Prot/PI Coor: Anne Resseau	Richmond Wilkes Lincoln Taliaferro Warren McDuffie Columbia	Community Service Board of East Central Georgia	F. Campbell Peery	3421 Mike Padgett Highway Augusta, GA 30906-3815 Telephone: (706) 771-4841 (Secretary) (706) 771-4953 FAX 706-771-4953
	Emanuel Glascock Jefferson Burke Jenkins Screven	Ogeechee Behavioral Health Services	J. Frank Brantley	P.O. Box 1259 Swainsboro, GA 30401-1259 Telephone: (912) 289-2522 FAX 912-289-2544
13 Ralph McCuin Director Nations Bank Plaza 777 Gloucester Street Suite 414 Brunswick, GA 31520 Phone 912-280-6893 FAX 912-280-6896 Board Chair: Chuck Chapman Secretary: Dawn Crews Utilization Mgr: Mitch Sweeney ASM: Brenda Moss Prevention Spec: Deanne Bergen Cons. Prot/PI Coor: Barbara Meyers	Bulloch Candler Evans Toombs Tattnall Jeff Davis Appling Wayne	Pineland Area MH, MR and SA Community Service Board	June DiPolito	P.O. Box 745 Statesboro, GA 30459-0745 Telephone: (912) 764-6906 FAX 912-489-3058
	Chatham Effingham	Tidelands Community Service Board	Al Quarterman	P.O. Box 23407 Savannah, GA 31403-3407 Telephone: (912) 651-2171 FAX 912-651-2893

Region	Counties in Service Area	CSB Name	Director	Address and Telephone Number
	Glynn Bryan Liberty Long McIntosh Camden	Gateway Community Service Board	Susan Broome	1609 Newcastle Street Brunswick, GA 31520-67 Telephone: (912) 267-4859 FAX 912-267-4868

2133 – DEEMING WAIVER (KATIE BECKETT)

POLICY STATEMENT

Deeming Waiver is a class of assistance (COA) available to children under age 18 who are financially ineligible for SSI.

These individuals are determined to be in need of institutionalized care, but have chosen to remain at home because they can be cared for at a lower cost. Deeming Waiver allows the deeming of the income and resources of the child's parents to be *waived* when determining ABD Medicaid eligibility.

BASIC CONSIDERATIONS

To be eligible under the Deeming Waiver COA, an A/R must meet the following conditions:

- The A/R is under 18 years of age.
- The A/R is chronically impaired to the extent of being a suitable candidate for institutionalized care.
- The A/R is financially ineligible for SSI in a private living arrangement (LA-A, B or C) due to his/her own income and/or resources or income/resources deemed from his/her parent(s).
- The A/R meets the Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

NOTE: Length of Stay (LOS) is **not** a requirement for this COA.

In some situations, a child may be eligible for either CCSP or Deeming Waiver. The benefits of each COA should be explained to the parent(s) or other personal representative. Also, the availability of CCSP services should be considered.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the Deeming Waiver COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Screen for SSI financial eligibility in one of the following ways:

- Complete a SSI trial budget in the system, deeming the income and resources of the child's parent(s). Refer to Section 2508, Deeming.
- Obtain a current SSI denial letter, if available.

If the child is financially eligible for SSI, deny the ABD Medicaid application and refer the child to SSA for a SSI determination.

PROCEDURES (cont.)

Step 3 (cont.) If the child is financially ineligible for SSI, proceed with the Deeming Waiver application.

NOTE: Review any reduction in the income or resources that makes the child eligible for SSI. Schedule interim reviews if changes are anticipated and terminate Deeming Waiver Medicaid if the child becomes eligible for SSI.

Step 4 Determine basic eligibility, including Level of Care (LOC) and establishing the child's disability using the SMEU process. If the child is determined not to be disabled by SMEU, deny the Deeming Waiver application for failure to meet the disability criteria. Refer to Chapter 2200, Basic Eligibility Criteria.

The LOC is obtained by completing Form DMA-6 and submitting to the Georgia Medical Care Foundation (GMCF) for approval.

The A/R's family, the attending physician and eligibility worker (EW) have roles in completing a DMA-6 on the A/R.

- Include the EW's name, county address and telephone number in Section A, Number 1.
- Include the A/R's family address and telephone number in Section A, Numbers 5 and 6.
- The primary physician in Section B, Number 18, must sign the DMA-6.
- The DMA-6 must be received at GMCF within 30 days of the date signed by the physician in Section B, Number 20.

Thoroughly complete a Social Data Report, Form 188. It must be signed and dated by the EW and received at GMCF within 90 days of the date on the form. A Social Data Report from another social worker familiar with the child's situation is also acceptable. The parent(s) should not complete Form 188.

The A/R's family, physician, and therapist (if the A/R is receiving any therapies) complete a care plan that outlines how the child's needs are met and the desire outcomes.

If developmental delay is indicated as a diagnosis, a psychological evaluation is completed by a Ph.D., M.Ed., Child Development Specialist (Babies Can't Wait), Developmental Pediatrician or School Psychologist to accompany the other forms which are sent to GMCF. At initial application, this evaluation must have been completed within the last year from the date received at GMCF.

PROCEDURES (cont.)

Send the following completed items to GMCF:

- DMA-6
- Care Plan
- Social Data Report, Form 188
- Psychological Evaluation if developmental delay is indicated
- Current therapy notes if therapy is indicated on the DMA-6.

GMCF reviews the DMA-6 and returns to DFCS with the results.

- The LOC criterion is met when an approved DMA-6 is received from GMCF. If a LOC is denied by GMCF, deny the Deeming Waiver application.
- Medicaid eligibility under the Deeming Waiver COA is not held to the payment date entered by GMCF in Section C, Number 37. Therefore, three months prior Deeming Waiver may be approved even if those months pre-date the payment date on the DMA-6.

NOTE: Receipt of an approved DMA-6 from GMCF is not verification of disability.

Step 5 Determine the child's suitability for care under a home care plan in lieu of institutionalized placement using the Physician's Referral Form and the Deeming Waiver Request Form.

Obtain a completed Physician Referral Form from the primary physician:

- Reproduce copies of this form locally (a copy is found at the end of this section).
- Give the form to the PR to have completed by the physician.
- Total the Medicaid covered cost that the physician estimates for non-institutionalized medical treatment.

Complete a Deeming Waiver Request Form as follows:

- Determine the total Medicaid cost of institutionalized care using the monthly Medicaid billing rate for the institution chosen by the A/R's family.
- Subtract the physician's estimated monthly cost of home care on the Physician's Referral Form from the monthly billing rate of the institution.

- If in-home care is **more** costly, **deny** the Deeming Waiver application.
- If in-home care is **less** costly, **approve** the Deeming Waiver application.

PROCEDURES (cont.)

Step 6 Approve Medicaid on the system by entering all pertinent data if the A/R meets all eligibility criteria, including any retroactive months. The system will determine financial eligibility using the Medicaid Cap. There is no patient liability for this COA.

Follow-Up Complete a review of eligibility annually and document any anticipated change in resources, income or potential SSI eligibility.

Submit a new Form DMA-6 and new care plan to GMCF to obtain a LOC. If development delay has previously been indicated as a diagnosis, a psychological evaluation is required by GMCF every third year of receipt of Medicaid under this COA. Submit current therapy notes if therapy is indicated on the DMA-6.

Obtain a new Physician's Referral Form to ensure that the cost of in-home care continues to be less than the cost of institutionalized care in order for eligibility to continue.

If the A/R becomes ineligible for Deeming Waiver Medicaid, terminate the case and complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

SPECIAL CONSIDERATIONS

SSI regulations allow a child who has received SSI in a LA-D situation to continue receiving SSI in a private living arrangement. The income and resources of the parent(s) are not considered if the child is approved under a state home health plan. In Georgia, the relevant home health plans are CCSP, Deeming Waiver and Model Waiver.

- Determine and verify a LOC and eligibility for the appropriate home health plan for SSI on these children. Refer to Step 5 in this section.

- Do not approve Deeming Waiver Medicaid for these children for any month that they are SSI eligible.

DEEMING WAIVER REQUEST FORM

Name of Applicant:_____

Name(s) or parent(s) or
responsible party:_____

Address:_____

_____

For purposes of cost comparison, the name of the medical treatment facility (MTF) that would be chosen if institutionalization became necessary is as follows:

_____

Name and address of the physician who will complete Form DMA-6:

_____

_____

Date of trial budget completed by DFCS showing financial ineligibility for SSI:_____

Date of SSI application:_____ Date of SSI denial:_____

Date of SSI approval:_____ Date of SSI termination:_____

CASEWORKER CHECKLIST	Requested	Received
• Form DMA-6	_____	_____
• Physician's Referral Form	_____	_____
• Verification of SSI ineligibility	_____	_____
• Verification of disability/SMEU submitted	_____	_____
• Estimated cost of MTF of choice	_____	_____
• Other_____	_____	_____

Monthly Medicaid Billing Rate of MTF: $_____

Estimated cost of in-home care: _____

Estimated Savings: $_____

DEEMING WAIVER
PHYSICIAN'S REFERRAL FORM

This information is requested for the purpose of determining your patient's eligibility for Medicaid.

Patient's Name:_____

Diagnosis:_____

Prognosis:_____

Estimated monthly costs of Medicaid covered services for in-home care:

- Physician's services $_____
- Durable medical equipment _____
- Drugs _____
- Other(s)_____ _____

TOTAL $_____

Will home care be as good or better than institutional care?

_____ Yes _____ No

COMMENTS:

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE _____

DATE: _____

2135 – HOSPICE CARE

POLICY STATEMENT

Hospice Care is a class of assistance (COA) that provides Medicaid to cover care for terminally ill individuals.

BASIC CONSIDERATIONS

To be eligible under the Hospice Care class of assistance an A/R must meet the following conditions:

- The A/R has a medical prognosis of six months or less life expectancy.
- The A/R is receiving hospice care services from an approved hospice care provider.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

Hospice care services are provided to the A/R by a Medicaid hospice agency. The A/R may reside at home or in a nursing home.

Hospice care services include but are not limited to the following:

- nursing home
- medical social services
- physician services
- counseling services
- respite care
- home health aide services.

NOTE: DMA only reimburses for medical services provided by the hospice care agency. These recipients receive a Medicaid card that identifies them as hospice care recipients, with a notation to medical service providers that all claims must be submitted through the hospice agency.

There is no patient liability or cost share under this COA.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the Hospice Care COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Verify the following through receipt of a Hospice Care Communicator (HCC) from the hospice agency:

- A/R's medical prognosis (life expectancy)
- A/R's (or PR's) election of hospice services
- Date hospice care services began.

Step 3 Conduct a face-to-face interview.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility.

- Refer to the Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.

- Complete a Medicaid CAP budget to determine income eligibility. Refer to the Section 2510, Medicaid CAP Budgeting.

Step 6 Approve Medicaid on the system using the Hospice Care COA if the A/R meets all the above eligibility criteria.

For an A/R receiving hospice care services in a **nursing home** who has income in excess of the Medicaid CAP, determine AMN eligibility by projecting the monthly cost of the hospice in the same manner as for an AMN nursing home case. See Section 2151, AMN Nursing Home.

Step 7 Notify the A/R of the case disposition via the system. Notify the hospice provider of the case disposition using the Hospice Care Communicator.

PROCEDURES (cont.)	
Step 8	Verify at the following intervals through receipt of an HCC that the hospice care provider has received a signed statement from the A/R electing to continue hospice care services: • by the end of the first 90 day period of hospice care • by the end of the second 90 day period of hospice care • every 60 days thereafter. **NOTE:** Do **not** approve Medicaid under the Hospice Care COA for any month in which the A/R will not receive hospice services from an approved hospice agency. If the A/R does not elect to continue hospice services at the intervals specified above, complete a CMD. Refer to the Section 2052, Continuing Medicaid Determination.
SPECIAL CONSIDERATIONS	For any month in which an A/R is in Hospice care **and** another COA such as Hospital or Nursing Home, approve the case on the system under the **other** COA. Use Hospice COA when the A/R is in Hospice and not eligible under any other COA for a particular month.

2137 - HOSPITAL

POLICY STATEMENT

The Hospital Class of Assistance (COA) provides Medicaid for individuals who are hospitalized for at least 30 consecutive days. The period of confinement may include a combination of days in either a Medicaid participating or non-Medicaid participating institution.

BASIC CONSIDERATIONS

To be eligible under Hospital COA, the A/R must meet the following conditions:

- The A/R is requesting Medicaid due to a stay in a Medicaid participating hospital.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the Hospital COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 4 Determine financial eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to Section 2510, Medicaid CAP Budgeting.

NOTE: There is no patient liability or cost share under this COA.

Step 5 Approve Medicaid on the system using the Hospital COA if the A/R meets all the above eligibility criteria.

NOTE: Do **not** approve Medicaid under the Hospital COA for any month in which the A/R was not hospitalized for at least one day of the month.

2138 – LAURENS COUNTY HEAD INJURY WAIVER

POLICY STATEMENT	Residents of Laurens County who are under 25 years of age and have a disabling head injury that causes respirator or oxygen dependency may be eligible for a special Medicaid eligibility and/or service waiver.
BASIC CONSIDERATIONS	Laurens County Head Injury waivered services are approved by the DMA Waivered Services Unit based on consultation with the injured individual's physician and/or hospital discharge planner.
PROCEDURES	If a Laurens County Medicaid recipient who meets the criteria described in the policy statement above requests waivered services, tell the recipient and/or the PR to have the physician or discharge planner contact DMA at the following address: Division of Medical Assistance Waivered Services Unit P. O. Box 38426 Atlanta, Georgia 30334 Telephone: (404) 656-6862 If a Laurens County resident not currently receiving Medicaid requests waivered services, determine Medicaid eligibility under the Deeming Waiver class of assistance (COA). Refer to Section 2133, Deeming Waiver. Tell the recipient and/or the PR to have the physician or discharge planner contact the DMA Waivered Services Unit to arrange waivered services. Contact your state Medicaid consultant for further instructions on a Medicaid eligibility waiver if the individual can not be determined eligible under the Deeming Waiver COA.

2139 – INDEPENDENT CARE WAIVER PROGRAM

POLICY STATEMENT

The Independent Care Waiver Program (ICWP) is a class of assistance (COA) that provides in home care to individuals who are severely Physically Disabled (SPD) or who have Traumatic Brain Injuries (TBI). These individuals need more care than can be provided by CCSP. ICWP A/Rs must meet the criteria for nursing home placement although they remain at home.

BASIC CONSIDERATIONS

To be eligible under this COA, an A/R must meet the following conditions:

- The A/R is at least 21 years of age.
- The A/R is receiving case management services through a DMA approved ICWP case management provider.
- The A/R is residing in a residential home situation, such as his/her own home.
- The A/R meets the length of stay (LOS) and the level of care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

ICWP Medicaid recipients receive certain *waivered* services not normally covered by Medicaid, including the following:

- case management
- companion services
- counseling
- emergency response system (ERS)
- environmental modification
- homemaker services
- occupational therapy
- personal care services
- skilled nursing
- specialized medical equipment and supplies
- transportation.

Refer any individuals interested in receiving services under ICWP to GMCF at (404) 982-0411 or 1-800-982-0411, extension 7319.

BASIC CONSIDERATIONS (cont.)

The case management provider (case manager) initiates the Form DMA-6 and the ICWP services approval process.

- The case manager submits Form DMA-6 with Independent Care Waiver written in red to GMCF. GMCF returns the approved Form DMA-6 to the case manager, who sends one copy to DFCS as verification of an approved LOC.

- The case manager submits an Individual Plan of Care and a Recipient Application form to the DMA Waivered Services Unit for approval of ICWP services. The Waivered Services Unit notifies the case manager of approval or denial of the A/R for ICWP services.

- If DMA approves the A/R, the case manager submits an Independent Care Waiver Communicator to DFCS, specifying the date case management began, which is used for LOS, and the date of the first waivered service, which serves as the slot date for eligibility purposes in the same manner as it is used under CCSP.

NOTE: The beginning date of case management and the slot date should be the same in most cases, since case management is a waivered service under ICWP.

If ICWP services are approved by DMA, the case manager and the A/R decide on service providers.

The A/R may apply for ICWP Medicaid while residing at home or in a hospital or nursing home.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the ICWP class of assistance.

Step 1 Accept the A/R's ABD Medicaid application.

Step 2 Conduct a face-to-face interview.

Step 3 Verify that the A/R is receiving ICWP services through receipt of an ICWP Communicator from the case manager. The ICWP Communicator should indicate the beginning date of case management and the slot date.

PROCEDURES (cont.)

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

NOTE: If DFCS has not received the Form DMA-6 within 30 days of the application date, contact the case manager to ensure that the Form DMA-6 was submitted to GMCF.

Step 5 The system determines financial eligibility. Consider the A/R to be in LA-D.

- See Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on whose resources to consider and the resource limit used in determining resource eligibility.
- Complete a Medicaid Cap budget to determine income eligibility. See Medicaid CAP Budgeting in Chapter 2510.

Step 6 The system determines the A/R's cost share using the Community Spouse Maintenance Need Standard (CSMNS) as the personal needs allowance (PNA) and all other policies applicable to patient liability/cost share budgeting.

Step 7 The system notifies the A/R of eligibility/cost share and transmits pertinent data to DMA via the interface.

NOTE: Do not approve Medicaid under the ICWP class of assistance for any month prior to the month of the slot date.

Step 8 Notify the ICWP Case manager by:

- Entering the Case Manager's name and address in the system as an Authorized Representative. The Case Manager will then receive information concerning dates of eligibility and cost share.

OR

- Completing Section II of the ICWP Communicator. Enter the Medicaid number on the top of the form. Send one copy to the Case Manager and retain the other in the case record.

SPECIAL CONSIDERATIONS

ICW Communicator (ICWC)

The ICWP class of assistance requires the Independent Care Waiver Communicator (ICWC) form as a means for the ICWP Case Manager to communicate with the DFCS Eligibility Worker. The Eligibility Worker may use this form or the system as a means of relaying ICWP approval, denial or termination information to the Case Manager. Make copies of this form, found at the end of this section, as needed.

The ICWC functions much like the Community Care Communicator (CCC). The form is initiated by the case manager and forwarded to DFCS after the A/R is approved for ICWP services by GMCF. The case manager completes the following sections of the ICWC:

- The top section, with all identifying information except the Medicaid number unless the A/R is already a Medicaid recipient.

- Section I, giving the date case management began, the slot date, and a request for a determination of Medicaid eligibility (if needed) and cost share amount.

INDEPENDENT CARE WAIVER COMMUNICATOR

Client Name	County	Medicaid Number
Client Address	Social Security #	Date of Birth

SECTION I – COMPLETED BY CASE MANAGER

I. The above-named client has elected to accept Independent Care Waiver Program services. Case Management began effective _____, and the client was placed in an ICWP slot effective _____.

[ ] The client is currently receiving Medicaid. Please determine cost share.
[ ] The client has been referred for Medicaid eligibility and cost share determination.

Signature _____ Date _____

SECTION II – COMPLETED BY DFCS CASEWORKER

II. [ ] The client has been determined Medicaid eligible effective _____.
[ ] The client is receiving Independent Care Waiver services and is responsible for contributing $_____ monthly toward the cost effective _____.
[ ] The client has a change in cost share.
$_____ Effective _____
$_____ Effective _____
$_____ Effective _____

[ ] The above named client has been determined ineligible for Medicaid effective _____. Reason:_____
_____.

[ ] Other _____
_____.

Signature _____ Date _____

SECTION III – COMPLETED BY CASE MANAGER

III. [ ] The above named client is being released from the Independent Care Waiver Program effective _____. Reason:_____
_____.

Signature _____ Date _____

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WAIVER APPROVAL FORM

TO: Recipient Data Base
Division of Medical Assistance
P.O. Box 38407
Atlanta, GA 30334

FROM: _____County Department of Family and Children Services

RE: _____
(Recipient's Name)

The above named person has been approved for:

[ ] Model Waiver
[ ] Independent Care Waiver: (check one) Severely Physically Disabled [ ]
Traumatic Brain Injury [ ]

Medicaid ID number: _____

Social Security Number:_____

Address: _____
_____

Sex: _____ DOB: _____ Race Code: _____

Application Date: _____ Approval Date: _____

Beginning Date of Eligibility: _____

Address changed to: _____
_____

Medicaid ID number changed to: _____

Class of assistance has been changed from _____ Waiver to _____ Waiver. Effective date: _____

Please indicate, if known, any month(s) the recipient is expected to have intermittent SSI eligibility: _____

_____ _____
Caseworker Date

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WAIVER TERMINATION FORM

TO: Recipient DataBase
Division of Medical Assistance
P.O. Box 38407
Atlanta, Georgia 30334

FROM: _____ County DFCS

RE: _____ (Recipient's Name)

[ ] The above named individual is no longer eligible for Medicaid based on the recipient of waiver services. Effective date: _____

Medicaid Number: _____

[ ] The above named client is no longer eligible to receive _____ Waiver services but continues to be Medicaid eligible under the _____ class of assistance. Effective date: _____

Medicaid Number: _____

Social Security Number: _____

Address: _____

_____

Reason for closure code: _____

_____ _____
Caseworker Date

Rev. 2/02

2140 – MODEL WAIVER PROGRAM

POLICY STATEMENT

The Model Waiver Program (MWP) provides specialized medical services to a Medicaid recipient who is under age 21 and respirator or oxygen dependent.

BASIC CONSIDERATIONS

A request for MWP services is made when an individual is in need of a particular medical service that is not usually covered by Medicaid. The Waiver Services Unit at DMA is responsible for determining appropriateness for these services.

To be eligible for MWP services, the A/R must meet the following conditions:

- The A/R is a Medicaid recipient under the most advantageous COA, including SSI, Family Medicaid or ABD Medicaid.
- The A/R is under the age of 21.
- The A/R is respirator or oxygen dependent.
- The A/R is approved for a nursing home level of care (LOC).
- The A/R is approved by the DMA Waiver Services Unit for MWP services.

The Waiver Services Unit at DMA is responsible for obtaining the required LOC unless Medicaid eligibility is determined under the Deeming Waiver COA.

Eligibility for MWP services is approved manually and is not entered on the DFCS system. All required forms used to contact DMA are reproduced locally.

PROCEDURES

Medicaid Recipient

Follow the steps below to initiate MWP services if the individual requesting these services is **currently** receiving Medicaid.

Step 1

Verify Medicaid eligibility.

Step 2

Verify that the A/R is under age 21.

Step 3

Document the PR's statement that the individual is respirator or oxygen dependent. File any supporting medical documentation in the case record.

PROCEDURES (cont.)

Step 4 Tell the PR to have the A/R's physician or hospital discharge planner contact the DMA Waiver Services Unit at the following address to arrange for MWP services:

Department of Medical Assistance
Waiver Services Unit
P. O. Box 38426
Atlanta, Georgia 30334
Telephone Number: (404) 656-6862

Explain to the PR that additional information may be required by DMA, such as Form DMA-6 completed by the physician.

NOTE: If the A/R is approved for MWP services, DMA notifies the county DFCS of the approval with a copy of the approval letter that is sent to the PR.

Step 5 Complete the Waiver Approval Form upon receipt of a copy of the MWP approval letter from DMA.

- Reproduce the form found in Section 2139, Independent Care Waiver Program.
- Submit the Waiver Approval Form to the DMA Recipient Data Base at the address indicated on the form.

Step 6 Review the income of the Model Waiver A/R. Contact a state Medicaid consultant regarding calculations of a cost share if the A/R has income in excess of the FBR for LA-A.

Changes in Medicaid or MWP Eligibility

Complete a CMD if an individual has been terminated from on-going Medicaid and is receiving MWP services. Refer to Section 2052, Continuing Medicaid Determination.

Notify the DMA Recipient Data Base of changes in eligibility for Medicaid under MWP services by completing the Waiver Approval Form or Waiver Termination Form and submitting it to the address on the form.

PROCEDURES (cont.)

Medicaid Applicant

Follow the steps below to determine Medicaid eligibility and initiate MWP services if the individual requesting these services is **not** receiving Medicaid.

Step 1 Accept the A/R's Medicaid application.

Step 2 Verify that the A/R is under age 21. Document the A/R's respirator or oxygen dependency in the case record.

Step 3 Screen for Medicaid eligibility under all COAs, including SSI, Family Medicaid and ABD Medicaid. Determine eligibility under the COA most advantageous to the A/R.

- If the A/R is ineligible for Medicaid under all other COAs and is a child under age 18, determine Medicaid eligibility under the Deeming Waiver COA.
- If eligibility is determined under the Deeming Waiver COA, forward a copy of the GMCF approved Form Dma-6 to the DMA Waiver Services unit as soon as it is returned to DFCS from GMCF.

Step 4 Tell the PR to have the A/R's physician or hospital discharge planner contact the DMA Waiver Services Unit. Refer to Step 4 of the Procedures to initiate MWP services for an individual who is currently receiving Medicaid listed above.

NOTE: MWP services cannot be approved while an application for Medicaid is pending.

Step 5 Complete the Waiver Approval Form upon receipt of a copy of the MWP approval letter from DMA.

- Reproduce the form found in Section 2139, Independent Care Waiver Program.
- Submit the Waiver Approval Form to DMA Recipient Data Base at the address indicated on the form.

Step 6 Notify the DMA Recipient Data Base of changes in eligibility for Medicaid under the Deeming Waiver or ICWP COAs **or** in eligibility for MWP services by completing the Waiver Approval Form or Waiver Termination Form and submitting it to the address on the form.

2141 – NURSING HOME

POLICY STATEMENT

Nursing Home is a class of assistance (COA) that provides Medicaid to individuals residing in a Medicaid participating nursing home.

BASIC CONSIDERATIONS

To be eligible under nursing home COA, an A/R must meet the following conditions:

- The A/R is in a Medicaid participating nursing home.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the Nursing Home COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Verify from the receipt of a Form DMA-59 from the nursing home that the A/R resides in a nursing home.

Step 3 Conduct a face-to-face interview (required at initial application only).

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to Section 2510, Medicaid CAP Budgeting.

PROCEDURES (cont.)

Step 6 Approve Medicaid using the Nursing home COA if the A/R meets all the above eligibility criteria. The system will determine the A/R's patient liability based on information entered.

NOTE: Do **not** approve Medicaid under the Nursing Home COA for any month in which the A/R was not confined to a nursing home for at least one day of the month.

Step 7 Notify the A/R and/or PR and the nursing home of the case disposition and patient liability via the system generated notice.

2143 - QUALIFIED MEDICARE BENEFICIARIES

POLICY STATEMENT	Qualified Medicare Beneficiaries (QMB) is a class of assistance (COA) that provides a Medicare supplement to individuals who meet financial criteria based on the Federal Poverty Level (FPL).
BASIC CONSIDERATIONS	To be eligible under this COA an A/R must meet the following conditions: • The A/R is entitled to Part A Medicare coverage. • The A/R meets all basic eligibility criteria. **EXCEPTION:** Application for Other Benefits, Length of Stay (LOS) and Level of Care (LOC) are **not** requirements under this COA. • The A/R has countable resources of less than or equal to twice the SSI resource limit. • The A/R has countable net income of less than or equal to the QMB income limit. QMB pays the following for the QMB eligible individual: • the monthly premium for Part A Medicare for those individuals who must pay a premium • the monthly premium for Part B Medicare • all Medicare co-insurance payments (the 20% of covered charges that Medicare will not pay) • all Medicare deductibles, such as the in-patient hospital deductible. QMB will **not** cover any medical service that is not covered by Medicare. Applicants for QMB must meet all eligibility criteria for this COA in the month of approval and the following month in order to be approved. There is no retroactive coverage under this COA. QMB eligibility begins the first day of the month following the month the eligibility determination is completed.

BASIC CONSIDERATIONS (cont.)

Persons who must pay a premium for Part A Medicare who also appear to be eligible for QMB will be referred to DFCS by SSA for a QMB determination prior to SSA's processing of the Part A Medicare application. SSA will process applications for Part B Medicare without regard to QMB eligibility.

An individual who has income less than the FBR may be eligible for QMB and not eligible for SSI because of excess resources.

In-kind Support and Maintenance (ISM) is **not** considered in determining QMB eligibility.

The QMB income limit is based on the FPL. The FPL/QMB income limit is subject to change between February and April of each year. Therefore, the annual January RSDI COLAs are disregarded in determining QMB eligibility until the effective month of the new QMB income limit.

Aged SSI Only recipients who are eligible for Part A Medicare with a monthly premium must apply for QMB at DFCS in order to have the premium paid by DMA. Refer to Special Considerations in this section for procedures on processing the QMB application for these individuals.

NOTE: THE STANDARD OF PROMPTNESS FOR QMB APPPLICATIONS IS 10 WORKING DAYS FROM RECEIPT OF THE APPLICATION.

SPECIAL CONSIDERATIONS

The 1999 Government Performance Results Act simplified the policy and procedures for this class of assistance, and has changed the application process. In addition to applying at the county office, an A/R may apply with the local Community Health Center or with HICARE on a simplified application form DCH 700, Medicare Savings for Individuals. (County DFCS shall also use this application form which is available from Central Supply.)

The local Community Health Center and HICARE will forward all applications to DMA, who will forward the applications to the appropriate County Departments. The application date is the date stamped as received by DMA.

PROCEDURES

Follow the steps below to determine QMB eligibility.

Step 1 Accept the A/R's QMB application.

NOTE: A face-to-face contact and office interview is not required at initial application or annual redetermination.

Step 2 Contact the A/R by telephone only if information provided on the application is not sufficient to process the case.

Step 3 Verify Part A Medicare entitlement by one of the following:

- client statement, if copy of card or other written verification is not provided or available
- a RSDI Award Letter
- a Medicare card
- BENDEX under Clearinghouse on the system
- a MBR Query Card
- notification from a local SSA office.

Step 4 Determine all basic eligibility criteria except LOS, LOC and Application for Other Benefits. Accept A/R's statement regarding citizenship and residency. Refer to Chapter 2200, Basic Eligibility Criteria.

NOTE: To fulfill the TPR requirement on a QMB applicant who reports a TPR, copy the application and send to the DMA TPL Unit. Attach a copy of the insurance card if available.

Step 5 Determine financial eligibility. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following:

- whose income and resources to consider
- which QMB income and resource limit (individual or couple) to use
- which eligibility budget to complete

NOTE: For all applications and annual redeterminations: The A/R's statement of income and resources provided on the application/review form is acceptable verification. No further verification is required unless questionable. If BENDEX/SDX or other information known to the agency indicates an amount different from the A/R's statement and is determined to be current, use this amount over the A/R's statement.

PROCEDURES (cont.)

EXCEPTPTION: If a Medicare eligible couple both apply for QMB, SLMB, QI-1 or QI-2 and they are not financially eligible based on income as a couple for any Q track COA, calculate their eligibility as individuals and approve each under whichever Q track COA they are eligible.

No property search is required for this class of assistance.

The Social Security number of a spouse who is not applying for benefits is **not** required unless eligibility cannot be established without it.

Step 6 Approve QMB on the system to begin the month **following** the month of case disposition if the A/R meets all the above eligibility requirements.

Step 7 Notify the A/R of the case disposition via the system generated notice.

SPECIAL CONSIDERATIONS

Processing a QMB Application on a SSI Only Recipient

SSI Only (no RSDI or RR income) recipients who are age 65 or older are eligible for Part A Medicare with a monthly premium. Effective August 1991, SSI Only recipients must apply for and be approved for QMB before DMA will pay the Part A Medicare premium through the buy-in process.

The following SSI Only recipients will receive a letter from DMA informing them of the need to apply for QMB:

- SSI applicants aged 65 or older who are newly approved by SSA to receive SSI
- SSI recipients who reach age 65

The SSI Only recipient must submit an application for QMB to the DFCS office in his/her county of residence.

Current SSI eligibility is prima facie evidence of financial eligibility for QMB. A screen print of the SDX record showing current SSI pay status is acceptable verification.

Follow the steps below to establish QMB eligibility for a SSI Only recipient.

Step 1 Register the applicant on the system.

SPECIAL CONSIDERATION (cont.)

Step 2 Contact the A/R by telephone.

NOTE: A face-to-face contact and office interview is not required.

Step 3 Document QMB financial eligibility based on receipt of SSI in SUCCESS.

Step 4 **NOTE:** A SSI certification letter is acceptable verification if SDX is not available.

Step 5 File the SDX screen print and copy of the DMA letter in the case record.

Verify potential Part A Medicare eligibility by use of one of the following:

- the DMA letter to the A/R regarding QMB and Buy-In
- the A/R's DOB on SDX showing current age as 65 or older
- AI at the end of the SSI claim letter
- a SSI certification letter.

If none of these methods of certification is available, request the A/R obtain a letter from SSA verifying potential eligibility for Part A Medicare entitlement.

Step 6 Approve on the system to begin the month **following** the month of case disposition if the A/R meets all above eligibility requirements.

Step 7 Notify the A/R of the case disposition via the system.

Review Process Redetermine eligibility in the month due by means of a telephone contact with the client and a screen print of SDX to show that the client remains in current SSI pay status.

Process the review in the system.

2144 – SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES

POLICY STATEMENT	Specified Low-Income Medicare Beneficiaries (SLMB) is a class of assistance (COA) that pays the monthly premium for Medicare Supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal poverty level (FPL).
BASIC CONSIDERATIONS	To be eligible under this COA, an A/R must meet the following conditions: • The A/R is entitled to Part A Medicare coverage. • The A/R meets all basic eligibility criteria. **EXCEPTION:** Application for Other Benefits, Third Party assignment, Length of Stay (LOS) and Level of Care (LOC) are **not** requirements under this COA. • The A/R has countable resources of less than or equal to twice the SSI resource limit. • The A/R has countable net income of less than the SLMB income limit but greater than the QMB income limit. SLMB pays only the monthly premium for Part B Medicare for the SMB eligible individual. Retroactive coverage (three months prior and intervening months) is allowed under this COA. SLMB eligibility cannot pre-date January 1993. The SLMB income limit is based on the federal Poverty level (FPL). The FPL/SLMB income limit is subject to change between February and April of each year. Therefore, the annual January RSDI COLAs are disregarded in determining SLMB eligibility until the effective month of the new SLMB income limit. In-kind support and maintenance (ISM) is **NOT** considered in determining SLMB eligibility. **NOTE: THE STANDARD OF PROMPTNESS FOR PROCESSING A SLMB APPLICATION IS 10 WORKING DAYS FROM THE DATE OF RECEIPT OF THE APPLICATION.**

SPECIAL CONSIDERATIONS

The 1999 Government Performance Results Act simplified the policy and procedures for this class of assistance, and has changed the application process. In addition to applying at the county office, an A/R may apply with the local Community Health Center or with HICARE on a simplified application form, DCH 700, Medicare Savings for Individuals. (County DFCS shall also use Form 700 for initial applications and annual reviews. It is available from Central Supply.)

The local Community Health Center and HICARE will forward all applications to DMA, who will forward the applications to the appropriate County Departments. The application date is the date stamped as received by DMA.

PROCEDURES

Follow the steps below to determine SLMB eligibility.

Step 1 Accept the A/R's SLMB application.

Step 2 Contact the A/R by telephone only if information provided on the application is not sufficient to process the case.

NOTE: A face-to-face contact and office interview is not required at initial application or annual redetermination.

Step 3 Verify Part A Medicare entitlement by one of the following:

- client statement, if copy of card or other written verification is not provided or available
- a RSDI Award Letter
- a Medicare card
- BENDEX under Clearinghouse on the system
- a MBR Query Card
- notification from a local SSA office.

NOTE: If the A/R has not been approved for Part A Medicare, but is entitled to free Part A, obtain notification from SSA and process SLMB as though the A/R is currently covered by Part A Medicare. (If an A/R is required to pay a premium to receive Part A Medicare, he/she is not considered entitled for purposes of eligibility for SLMB.)

Step 4 Determine all basic eligibility criteria except LOS, LOC and Application for Other Benefits. Accept the A/R's statement regarding citizenship and residency. Refer to Chapter 2200, Basic Eligibility Criteria.

PROCEDURES (cont.)

NOTE: To fulfill the TPR requirement on a SLMB applicant who has a TPR, copy the application and send to DMA only if the SLMB applicant becomes Medicaid eligible under another COA. Attach a copy of the insurance card if available.

Step 5 Determine financial eligibility using SLMB income and resource limits. Refer to the **Chapter 2500, ABD Financial Responsibility and Budgeting** to determine the following:

- whose income and resources to consider
- which SLMB income and resource limit (individual or couple) to use
- which eligibility budget to complete.

NOTE: For all applications and annual redeterminations: The A/R's statement of income and resources provided on the application/review form is acceptable verification. No further verification is required unless questionable. If BENDEX/SDX or other information known to the agency indicates a different amount from the A/R's statement and is determined to be current, use this amount over the A/R's statement.

EXCEPTION: If a Medicare eligible couple both apply for QMB, SLMB, QI-1 or QI-2 and they are not financially eligible based on income as a couple for any Q track COA, calculate their eligibility as individuals and approve each under whichever Q track COA they are eligible.

No property search is required for this class of assistance.

The Social Security number of a spouse who is not applying for benefits is **not** required unless eligibility cannot be established without it.

Step 6 Approve SLMB using the following procedures if the A/R meets all the above eligibility requirements:

- Enter the information in the SUCCSS system as QO1. The case will trickle from QMB to SLMB.

Step 7 Notify the A/R of the case disposition via the system generated notice.

2145 - QUALIFYING INDIVIDUALS - 1

POLICY STATEMENT

Qualifying Individuals – 1 (QI-1) is a class of assistance (COA) that pays the monthly premium for Medicare supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal Poverty Level (FPL). Eligibility criteria are identical to SLMB except that the coverage is time limited depending on available State funds and the income limit is higher than the SLMB limit.

BASIC CONSIDERATIONS

To be eligible under this COA, an A/R must meet the following conditions:

- The A/R is entitled to Part A Medicare coverage.
- The A/R meets all basic eligibility criteria.

EXCEPTION: Application for Other Benefits, Third Party assignment, Length of Stay (LOS) and Level of Care (LOC) are not requirements under this COA.

- The A/R has countable resources of less than or equal to twice the SSI resource limit.
- The A/R has countable net income of less than QI-1 income limit but greater than the SLMB income limit.

QI-1 pays only the monthly premium for Part B Medicare for the QI-1 eligible individual.

Retroactive coverage (three months prior and intervening months) is allowed under this COA. QI-1 eligibility cannot pre-date January 1998.

The QI-1 income limit is based on the Federal Poverty Limit (FPL). The FPL/QI-1 income limit is subject to change between February and April of each year. Therefore, the annual January RSDI COLAs are disregarded in determining QI-1 eligibility until the effective month of the new QI-1 income limit.

In-kind support and maintenance (ISM) is **NOT** considered in determining QI-1 eligibility.

NOTE: The Standard of Promptness for processing a QI-1 application is 10 working days from the date of receipt of the application.

SPECIAL CONSIDERATIONS

The 1999 Government Performance Results Act simplified the policy and procedures for this COA, and has changed the application process. In addition to applying at the county office, an A/R may apply with the local Community Health Center or with HICARE on a simplified application form, DCH 700, Medicare Savings for Individuals. (County DFCS shall also use Form 700 for initial applications and annual reviews. It is available from Central Supply.)

The local Community Health Center and HICARE will forward all applications to DMA, who will forward the applications to the appropriate county departments. The application date is the date stamped as received by DMA.

PROCEDURES

Follow the steps below to determine QI-1 eligibility.

Step 1 Accept the A/R's QI-1 application. Since this is a time limited program, it is important to take and process applications in chronological order.

Step 2 Contact the A/R by telephone only if information provided on the application is not sufficient to process the case.

NOTE: A face-to-face contact and office interview is not required at initial application or annual redetermination.

Step 3 Verify Part A Medicare entitlement by one of the following:

- client statement, if copy of card or other written verification is not provided or available
- a RSDI Award Letter
- a Medicare card
- BENDEX under Clearinghouse on the system
- an MBR Query Card
- notification from a local SSA office.

NOTE: If the A/R has not been approved for Part A Medicare but is entitled to free Part A, obtain notification from SSA and process QI-1 as though the A/R is currently covered by part A Medicare. (If an A/R is required to pay a premium to receive Part A Medicare, they are not considered entitled for purposes of eligibility for QI-1.)

PROCEDURES (cont.)

Step 4 Determine all basic eligibility criteria except LOS, LOC and Application for Other Benefits. Accept A/R's statement regarding citizenship and residency. Refer to Chapter 2200, Basic Eligibility Criteria.

NOTE: To fulfill the TPR requirement on a QI-1 applicant who has a TPR, copy the application and send to DMA only if the QI-1 applicant becomes Medicaid eligible under another COA.

Step 5 Determine financial eligibility using the QI-1 income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- whose income and resources to consider
- which QI-1 income and resource limit (individual or couple) to use
- which eligibility budget to complete.

The Social Security number of a spouse who is not applying for benefits is **not** required to process an application unless eligibility cannot be established without it.

NOTE: For all applications and annual redeterminations: The A/R's statement of income and resources provided on the application/review form is acceptable verification. No further verification is required unless questionable. If BENDEX/SDX or other information known to the agency indicates an amount different from the A/R's statement and is determined to be current, use this amount over the A/R's statement.

EXCEPTION: If a Medicare eligible couple both apply for QMB, SLMB, QI-1 or QI-2 and they are not financially eligible based on income as a couple for any Q track COA, calculate their eligibility as individuals and approve each under whichever Q track COA they are eligible.

No property search is required for this class of assistance.

An individual cannot be dually eligible for QI-1 and another Medicaid COA for ongoing eligibility. If an active QI-1 A/R applies for and is approved ongoing under another COA, close the QI-1 case.

Step 6 Approve QI-1 on the system if A/R meets all the above eligibility requirements.

Step 7 Notify the A/R of case disposition via the system generated notice.

2146 – QUALIFYING INDIVIDUALS - 2

POLICY STATEMENT	Qualifying Individuals – 2 (QI-2) is a class of assistance (COA) in which Medicaid pays 1/7 percent of the amount of the Medicare home health benefits being transferred from Medicare Part A to Medicare Part B. QI-2 individuals must meet financial criteria based on a percentage of the Federal Poverty Level (FPL). Eligibility determination is identical to QI-1 except that the coverage is time limited depending on available State funds and the income limit is higher than the QI-1 limit.
BASIC CONSIDERATIONS	To be eligible under this COA, an A/R must meet the following conditions: • The A/R is entitled to Part A Medicare coverage. • The A/R meets all basic eligibility criteria. **EXCEPTION:** Application for Other Benefits, Third Party assignment, Length of Stay (LOS) and Level of Care (LOC) are **not** requirements under this COA. • The A/R has countable resources of less than or equal to twice the SSI resource limit. • The A/R has countable net income of less than the QI-2 income limit but greater than the QI-1 income limit. QI-2 pays only 1/7 percent of the cost of the Medicare home health benefit, which is transferred to Part B Medicare. This amount is subject to change every year with the COLA. Retroactive coverage (three months prior and intervening months) is allowed under this COA. QI-2 eligibility cannot pre-date January 1998. The QI-2 income limit is based on the Federal Poverty Level (FPL). The FPL/QI-2 income limit is subject to change between February and April of each year. Therefore, the annual January RSDI COLAs are disregarded in determining QI-2 eligibility until the effective month of the new QI-2 income limit. In-kind support and maintenance (ISM) is **not** considered in determining QI-2 eligibility: **NOTE:** The Standard of Promptness for processing a QI-2 application is 10 working days from the date of receipt of the application.

SPECIAL CONSIDERATIONS

The 1999 Government Performance Results Act simplified the policy and procedures for this class of assistance, and has changed the application process. In addition to applying at the county office, an A/R may apply with the local Community Health Center or with HICARE on a simplified application form, DCH 700, Medicare Savings for Individuals. (County DFCS shall also use this application form, which is available from Central Supply, or reproduce it locally.)

The local Community Health Center and HICARE will forward all applications to DMA, who will forward the applications to the appropriate County Departments. The application date is the date stamped as received by DMA.

PROCEDURES

Follow the steps below to determine QI-2 eligibility.

Step 1 Accept the A/R's QI-2 application. Since this is a time-limited program, it is important to take and process applications in chronological order.

Step 2 Contact the A/R by telephone only if information provided on the application is not sufficient to process the case.

NOTE: A face-to-face contact and office interview is not required at initial application or annual redetermination.

Step 3 Verify Part A Medicare entitlement by one of the following:

- client statement, if copy of card or other written verification is not provided or available
- a RSDI Award Letter
- a Medicare card
- BENDEX under Clearinghouse on the system
- a MBR Query Card
- notification from a local SSA office.

NOTE: If the A/R has not been approved for Part A Medicare, but is entitled to free Part A, obtain notification from SSA and process QI-2 as though the A/R is currently covered by Part A Medicare. (If an A/R is required to pay a premium to receive Part A Medicare, he/she is not considered entitled for purposes of eligibility for QI-2.)

Step 4 Determine all basic eligibility criteria except LOS, LOC and Application for Other Benefits. Refer to Chapter 2200, Basic Eligibility Criteria.

PROCEDURES (cont.)

NOTE: To fulfill the TPR requirement on a QI-2 applicant who has a TPR, copy the application and send to the DMA TPL Unit only if the QI-2 applicant becomes Medicaid eligible under another COA. Attach a copy of the insurance card if available.

Step 5 Determine financial eligibility using QI-2 income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following:

- whose income and resources to consider
- which QI-2 income and resource limit (individual or couple) to use
- which eligibility budget to complete.

NOTE: For all applications and annual redeterminations: The A/R's statement of income and resources provided on the application/review form is acceptable verification. No further verification is required unless questionable. If BENDEX/SDX or other information known to the agency indicates an amount different from the A/R's statement and is determined to be current, use this amount over the A/R's statement.

EXCEPTION: If a Medicare eligible couple both appy for QMB, SLMB, QI-1 or QI-2 and they are not financially eligible based on income as a couple for any Q track COA, calculate their eligibility as individuals and approve each under whichever Q track COA they are eligible.

No property search is required for this class of assistance.

The Social Security number of a spouse who is not applying for benefits is **not** required unless eligibility cannot be established without it.

An individual cannot be dually eligible for QI-2 and another Medicaid COA for ongoing eligibility. If an active QI-2 A/R applies for and is approved ongoing under another COA, close the QI-2 case.

Step 6 Approve QI-2 on the system if A/R meets all the above eligibility requirements.

Step 7 Notify the A/R of case disposition via the system generated notice.

2147 – QUALIFIED DISABLED WORKING INDIVIDUALS

POLICY STATEMENT	Qualified Disabled Working Individuals (QDWI) is a class of assistance (COA) that provides payment of the monthly Part A Medicare premium for disabled working individuals.
BASIC CONSIDERATIONS	To be eligible for QDWI coverage, an A/R must meet the following conditions: • The A/R is under the age of 65. • The A/R is entitled to but not receiving RSDI disability benefits because s/he has earnings that exceed the substantial gainful activity (SGA) limits. • The A/R is eligible for Part A Medicare coverage with a monthly premium. • The A/R meets all basic and financial eligibility criteria. **NOTE:** Length of Stay (LOS), Level of Care (LOC) and TPR assignment are **not** requirements of this COA. In-kind support and maintenance (ISM) is **not** considered in determining QDWI eligibility. The only coverage this COA provides is payment of the monthly Part A Medicare premium by Medicaid. No other medical expenses incurred by the QDWI recipient is paid by Medicaid. A Medicaid card is not issued to QDWI recipients and Form 962 and 964 are not issued to the recipient or providers. QDWI eligibility cannot begin prior to the A/R's eligibility for Part A Medicare.
PROCEDURES	Follow the steps below to determine QDWI eligibility.
Step1	Accept the A/R's Medicaid application.
Step 2	Conduct a face-to-face interview.
Step 3	Determine that the A/R is ineligible for full Medicaid coverage under all other COAs.

PROCEDURES (cont.)

Step 4 Verify the following using the letter issued to the A/R by SSA:

- The termination of the A/R's RSDI disability payment due to excessive earned income.
- The A/R's eligibility for Part A Medicare coverage with a monthly premium.

Step 5 Determine all basic eligibility criteria except LOS, LOC and TPR. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 6 Determine financial eligibility using the current QDWI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following:

- whose income and resources to consider
- which SSI income and resource limit (individual or couple) to use
- which eligibility budget to complete.

Step 7 Approve on the system using the appropriate COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

2150 – ABD MEDICALLY NEEDY

POLICY STATEMENT

ABD Medically Needy (AMN) is a class of assistance (COA) that provides Medicaid coverage for aged, blind or disabled individuals whose income and/or resources exceed income and resource limits for all other ABD Medicaid COAs.

There are two types of Medically Needy cases.

- **De facto eligible** occurs when the A/R's net countable income is less than or equal to the ABD Medically Needy Income Level (AMNIL) and resources are less than or equal to the AMN resource limit.

- **Spenddown eligible** occurs when the A/R's net countable income is greater than the AMNIL. The amount of income greater than the AMNIL, called the spenddown, is offset by incurred medical expenses. Resources must also be less than or equal to the AMN resource limit.

BASIC CONSIDERATIONS

AMN coverage is potentially available to aged, blind or disabled individuals who have been determined to be financially ineligible under all other ABD Medicaid COAs.

Eligibility for SSI and all other ABD Medicaid COAs except Q track must be ruled out before determining eligibility under AMN.

Resource Limits

The resource limit used for an AMN individual is the SSI Individual resource limit.

The resource limit used for an AMN couple or an AMN individual with an ineligible spouse is twice the SSI Individual resource limit.

Review Period

In AMN, the review period is for six months. Each month of the six-month review period is a separate budget period. Eligibility is determined for each month individually. The review period begins on the first day of the month in which the application is filed and runs through the last day of the sixth consecutive month.

For three months prior, each month is also a separate budget period.

De Facto Eligible

If the A/R's monthly countable income is equal to or less than the AMNIL, the A/R is de facto eligible for Medicaid. Eligibility begins on the first day of the month.

BASIC CONSIDERATIONS (cont.)

Spenddown Eligible

If the A/R's monthly countable income is greater than the AMNIL, the excess amount is called the spenddown.

This spenddown must be met before the A/R can be approved for Medicaid under AMN.

The spenddown is met by subtracting allowable medical expenses from the spenddown amount until the spenddown reaches zero.

When the spenddown is met, the A/R is considered spenddown eligible, and the A/R is approved for Medicaid effective the day spenddown is met through the end of the month.

The following individuals' medical expenses can be used in meeting the spenddown:

- the A/R
- the A/R's **legal** ineligible spouse
- the A/R's **non-legal** ineligible spouse only if the second potential spenddown is used as the AMN spenddown
- the A/R's ineligible child
- the A/R's ineligible parent if the A/R is a child
- the deceased spouse or child of the A/R if the A/R remains liable for payment of the bill
- the child of the A/R who has reached 18 years of age if the child was under 18 at the time the medical expense was incurred and the A/R remains liable for the bill.

NOTE: The child does not have to be currently living in the home with the A/R.

Medical expenses are used to meet the spenddown if they meet all of the following conditions:

- The bill is unpaid as of the first day of the month, or is incurred or paid during the budget period.

- The A/R or deemor is legally obligated to pay the expense of the people listed on page 2150-2.

BASIC CONSIDERATIONS (cont.)

Spenddown Eligible (cont.)

- There is no third party resource (TPR) that is liable for payment of the expense. Refer to Special Considerations in this section and Chart 2150.1, Allowable medical Expenses in AMN. **NOTE:** VA Aid and Attendance is **NOT** a TPR.

- The bill is medically necessary. Any expense ordered or prescribed in writing by a medical practitioner recognized under state law is medically necessary. Doctor and hospital services are considered medically necessary.

The spenddown may be met using medical expenses incurred prior to the month. If this occurs, the A/R is eligible from the first day of the month.

If the spenddown is not met by previously incurred bills, the case is placed in suspense until enough bills are incurred to meet the spenddown or until the end of the month, whichever occurs first.

If the spenddown is met during the month, a first day liability (FDL) is computed for the day the spenddown is met. The A/R is responsible for paying this FDL. Form 400, Medically Needy First Day Liability, is used to inform the provider that the A/R is responsible for the FDL.

An A/R can submit medical expenses incurred during a given month up to the third month **after** the end of that month to be used in the spenddown for that given month. Bills submitted after the third month of any given month can be used in subsequent months if the bill meets all criteria for an allowable deduction.

If an A/R becomes eligible under another COA during a month while the case is in suspense, change the COA and begin eligibility effective the first day of that month.

Begin Authorization Date

Medicaid eligibility begins on a specific day in the month. This day is called the Begin Authorization Date (BAD).

NOTE: Medical expenses incurred prior to the BAD in a month will not be paid by Medicaid.

BASIC CONSIDERATIONS (cont.)

Begin Authorization Date (cont.)

The BAD can be any one of the following dates:

- the first day of the month if de facto eligibility is established
- the first day of the month if the spenddown is met using only unpaid medical bills incurred prior to the month
- the day in the month in which the spenddown is met using bills incurred during the month or a combination of bills incurred during and prior to the month. (This day could also be the first day of the month.)

PROCEDURES

Screen for eligibility for SSI and all other classes of ABD Medicaid.

If the A/R is ineligible for SSI based on income, resources or alien status and is ineligible for all other COAs, proceed with AMN. (See section on Citizenship and Alienage to determine which aliens are potentially Medicaid eligible.)

Follow the steps below to establish eligibility for ABD Medicaid under AMN.

Step 1 Accept the Medicaid application from the A/R and establish the six month review period.

Step 2 Conduct a face-to-face interview.

Determine all basic eligibility criteria except length of stay (LOS) and level of care (LOC).

NOTE: Complete Form DMA-285, Third Party Liability (TPL), to determine if a resource exists that will pay for all or a portion of the A/R's medical expenses.

Step 3 Establish financial responsibility. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following:

- whose income and resources to consider
- which AMNIL and AMN resource limit (individual or couple) to use
- which eligibility budget to complete.

PROCEDURES (cont.)

Step 4 Determine the countable resources of the A/R for the first month of the review period and all requested prior months and compare to the appropriate resource limit to determine resource eligibility.

Step 5 Enter appropriate income for the A/R and/or deemor into the system.

Defacto Eligibility

Step 6 If the A/R's net countable income is less than or equal to the appropriate AMNIL, the A/R is de facto eligible. Approve the A/R for Medicaid effective the first day of the month.

If the case is not de facto eligible, proceed to Step 7.

Spenddown Eligibility

Step 7 If the A/R's net countable income exceeds the appropriate AMNIL, the amount of the excess is the spenddown. Explain the spenddown concept to the A/R.

Step 8 Determine whose expenses are allowed to be deducted from the spenddown. Refer to Basic Considerations in this section.

Step 9 Obtain copies of any unpaid medical expenses and those paid during the month for the individuals determined in Step 8.

If a TPR exists, determine how much the TPR will pay on these bills and subtract this amount from the bill. Deduct only the remaining amount from the spenddown.

Refer to Special Considerations and to Chart 2150.1, Allowable Medical Expenses for AMN.

If the A/R is a self-payer for the Medicare premium, allow the premium as the first deduction for each month of the review period. NOTE: This is an exception to the policy of deducting bills in chronological order. The Medicare premium can be deducted the first of each month even if the A/R has other deductible bills incurred prior to the first of the month.

PROCEDURES (cont.)

Step 10 Enter allowable medical expenses in the system ensuring that all information is correctly entered prior to authorizing the spenddown. Authorize spenddown and complete Form(s) 400 as needed, either manually or in the system.

Notify the A/R, PR and DMA of eligibility dates and first day liability via the system generated notice. Do not send a Form 400 to DMA.

NOTE: If the AMN cannot be processed in the system, follow the steps below to determine spenddown manually:

Arrange the remaining allowable medical expenses in chronological order by date incurred.

Deduct from the spenddown allowable medical expenses incurred prior to the month in chronological order.

If the spenddown is met using prior medical expenses, approve Medicaid for the A/R from the first day of the budget period.

If the spenddown is **not** met, proceed to Step 11.

Step 11 Deduct from the spenddown allowable medical expenses incurred during the month in chronological order.

Rank medical expenses incurred on the same day as follows:

1. expenses incurred by an ineligible spouse or ineligible child
2. expenses incurred by the A/R but not covered by Medicaid (non-covered items such as over-the-counter drugs or bills payable to non-Medicaid providers)
3. remaining expenses, low to high, incurred by the A/R that are payable to a Medicaid provider.

If the spenddown is met, proceed to Step 12.

If the spenddown is **not** met, proceed to Step 14.

PROCEDURES (cont.)

Step 12 If the spenddown is met by bills in ranking order 1 or 2, Form 400 is not required. Complete the following actions:

- Approve the A/R for Medicaid to begin on the day in which the bill that brought the spenddown to zero (the break-even bill) was incurred.
- Send notice to the A/R. Include the BAD, the ending date of eligibility and the A/R's Medicaid number.
- Complete Form 964 for all retroactive months. Enter $0 as the First Day Liability Amount.

If the spenddown is met by bills in ranking order 3, Form 400 is required. Complete the following actions:

- Issue a Form 400 for the break-even bill showing the amount of the bill that was applied to the spenddown as the client liability. **NOTE:** The Form 400 can be issued to either the A/R or to a provider. Discuss with the A/R and determine to whom the Form 400 should be issued.
- Issue Form 400 with a client liability of zero for any other Medicaid covered bills incurred on the BAD that were not used to meet the spenddown.
- The Form 964 will contain the following:
  - The amount of the break-even bill used to meet the spenddown as the First Day Liability Amount.
  - **Form 400 is required** in the comments section.
  - The month, **day**, and year of the beginning and ending dates of eligibility.

NOTE: For group practices, indicate the specific individual who performed the medical service on Form 400, not the group name.

NOTE: Hospitals often submit a consolidated bill to the A/R, which is used to meet spenddown. If requested issue Form(s) 400 to any individual providers whose bill was included in the consolidated bill. Include the FDL on the Form 400 for the hospital, but not on the Form 400 for the individual provider.

PROCEDURES

Step 12 (cont.)

- Send notice to the A/R, including the BAD, FDL and the A/R's Medicaid number.

Suspense

Step 13 If the spenddown is **not** met, place the case in suspense until enough medical expenses are incurred to meet the spenddown.

Step 14 Subtract verified allowable medical expenses from the spenddown as they are presented by the A/R using the ranking order in Step 11.

Step 15 Deduct any medical expenses incurred during the month as they are provided by the A/R.

Step 16 If the spenddown is met during the month, approve Medicaid as of the day spenddown is met.

If the spenddown is **not** met during the month, begin the spenddown determination for the next month.

SPECIAL CONSIDERATIONS

Allowable Medical Expenses

The following types of medical expenses can be used to meet the AMN spenddown:

- Services provided by the following:
  - Chiropractors
  - Dentists
  - Hospitals
  - LPNs
  - Medical Clinics
  - Mental Health Clinics
  - MR Group Homes (the daily rate for treatment and training)
  - Nursing Assistants
  - Opticians
  - Optometrists
  - Osteopaths
  - Oculists
  - Personal Attendants (sitters)
  - Physicians
  - Psychiatrists
  - RNs

SPECIAL CONSIDERATIONS (cont.)

Allowable Medical Expenses (cont.)

- Medical care purchases, such as the following:
  - medical tests
  - hearing aids
  - eye glasses
  - contact lens
  - dentures
  - prescription drugs
  - over-the-counter medical needs
  - transportation cost to obtain medical services (allow $.25 for a mile or actual cost, whichever is less)
  - prosthetic devices
  - immunizations
- Elective surgery
- Health insurance premium
- Medically necessary ambulance service

NOTE: These lists are not all inclusive. Explore TPR coverage before applying any medical expense as a deduction from the spenddown.

Verification of Medical Expense

Verify incurred medical expenses by one of the following:

- medical bills or statements
- receipts for payment of medical expenses
- medical Explanation of Benefits (EOB) which shows covered/non-covered and paid/unpaid medical expenses
- health insurance statements showing amount paid
- odometer reading for mileage cost
- other appropriate means.

SPECIAL CONSIDERATIONS (cont.)

Use the following chart to determine which medical expenses can be deducted to meet the spenddown in an AMN case:

CHART 2250.1 – ALLOWABLE MEDICAL EXPENSES FOR AMN

ALLOWABLE	NOT ALLOWABLE
• Medical bills belonging to individuals who are or could have been included in the BG when the expenses were incurred. • Unpaid bills that the A/R or deemor remains liable for paying. • Unpaid bills incurred **prior** to the month which were not used to meet a spenddown for another month. • Bills incurred during the month, whether paid or unpaid. • Bills applied to an earlier spenddown that was never met if the bills are still owed and the individual who incurred them is still a deemor or A/R's minor child. • Medical bills used in ARM AMN budgets in the spenddown process. • Bills not presented to the worker during the month provided the A/R or deemor remains liable for payment as of the first day of the next month under consideration. • **Prior months AMN only**: past medical debts which have been forgiven or written off subsequent to the prior month. • The remainder of unpaid bills incurred prior to the month that have been turned over to a collection agency. If these medical bills are consolidated with other bills, only the portion that can be verified as unpaid medical expenses can be deducted. **NOTE:** Monthly payments to a collection agency cannot be deducted. • Medical expenses related to pregnancy, including prepayment of delivery fees or admission fees by the hospital when billed. • **Emergency Medical Assistance COA:** Bills from any time period can be used as long as the A/R or deemor still has a legal obligation to pay the bill. The incurred bills are not limited to the time of the emergency service. • Medical bills that have been paid with the proceeds of a loan if the loan has not been fully repaid. If other expenses were also paid by the loan, consider any and all payments made on the loan to be for the medical bills. • Medicare premiums for an A/R who is a self-payer are deductible the first day of each month, even if A/R is eligible as of the first day of the month using bills from previous months.	• Medical bills past or present which are subject to payment by a third party resource (TPR). VA Aid and Attendance is **not** a TPR. **EXCEPTION:** If there is a deductible or co-payment amount to be paid by the A/R, this can be allowed. If a decision is pending as to who is liable, do **not** allow the deduction until the decision on liability is made. If a bill is paid in full or in part to a provider or as a reimbursement to the A/R or deemor by a public program funded by the state or programs of political subdivisions of the state, allow this as a deduction, as long as **no federal funds** are used. Verify the source of the funding to ensure that there are no federal funds. **NOTE:** Allow a reimbursement for this third party only **if** the bill was paid by the A/R and reimbursed in the same month. Do not allow the bill as a deduction if the A/R paid the incurred expenses prior to the current month and was reimbursed in the current month. • For ongoing AMN, past medical debts which were forgiven or written off by the provider prior to the first day of the month or prior to the date the case is brought to final disposition. • Medical expenses paid by Medicaid under three months prior coverage. • Medical bills applied in another month in which spenddown is met.

SPECIAL CONSIDERATIONS (cont.)

Processing the AMN

Since AMN eligibility is determined for a time limited review period, the A/R must apply for AMN at the beginning of each new review period.

- Complete a full eligibility determination with the A/R's first application, including a signed application, completion of a full interview guide, property search and full verification as required for an initial application under any other ABD Medicaid COA.

- For each successive review period, complete an alternate review of eligibility using the procedures in the section entitled **Reviews.** Complete a face-to-face contact with the A/R once every twelve months.

- Complete a standard review only if twelve months or more has elapsed since the beginning of the last AMN review period.

NOTE: If an SMEU decision is used to verify disability at the point of initial AMN application, the SMEU decision is verification of disability for all successive AMN applications unless SMEU requests a review of disability.

Standard of Promptness

The SOP for an AMN application is met when all basic and financial eligibility criteria are met and the A/R is either notified in writing of the amount of the spenddown, or A/R is approved if spenddown is already met.

Extending the Ongoing Budget Period

Approve Medicaid under AMN for up to twelve successive ongoing months if the following conditions are met:

- The A/R has stable income and resources.
- The A/R has incurred allowable medical expenses that exceed **at least** twice the spenddown amount for one month.

Require the A/R to complete the eligibility review forms for each ongoing review period. Complete a face-to-face contact once every twelve months.

SPECIAL CONSIDERATIONS (cont.)

QMB/SLMB Recipient Applies for AMN

An individual who is eligible for ongoing QMB or SLMB does not have to file a separate application for AMN. The A/R must make his/her intentions known by requesting AMN verbally or by a written statement. Document the case record accordingly. If the A/R submits medical bills not covered by QMB/SLMB, consider it a request for AMN.

Determine AMN eligibility for:

- the month the bill is received by the EW

OR

- any of the three prior months

OR

- the ongoing month.

The medical bill has to meet all criteria for being an allowable deduction for the month under consideration.

EXCEPTION: A QMB or SLMB application filed on a DCH Form 700 cannot be used as an application for full Medicaid benefits.

TYPE OF CASE	BAD	FDL	400s REQUIRED	TRANSMIT ELIGIBILITY VIA	964 TO A/R
De Facto	First Day of BP	$0	NONE	System	See note
SD: Unpaid break-even bill incurred prior to BP	First Day of BP	$0	None	System	See note
SD: Unpaid Medicaid covered, break-even bill Incurred by A/R during the BP	Date of break-even bill	Amount of break-even bill applied to SD	Break-even bill and any other of A/R's Medicaid covered bills incurred on BAD, but not needed to meet SD	System	See note
SD: Break-even bill not covered by Medicaid and incurred during BP	Date of break-even bill	$0	NONE	System	See note

NOTE: The system generated notice, which includes Medicaid eligibility information, replaces Form 964. Only complete a Form 964 if eligibility cannot be entered into the system, such as a three month prior application that is greater than 13 months old.

2151 – ABD MEDICALLY NEEDY FOR NURSING HOME RESIDENTS/ HOSPICE CARE RECIPIENTS

POLICY STATEMENT

ABD Medically Needy (AMN) eligibility for a resident of a nursing home or hospice care recipient **residing in a nursing home** is determined by applying the projected monthly nursing home/hospice care private pay billing rate to the A/R's monthly AMN spenddown.

BASIC CONSIDERATIONS

De Facto Eligibility

When the projected monthly nursing home/hospice care private pay billing rate exceeds the monthly spenddown amount, eligibility and vendor payment are approved as of the first day of the month. There is no vendor payment for Hospice Care recipients.

Spenddown Eligibility

When the projected monthly nursing home private pay billing rate does **not** exceed the monthly spenddown amount, eligibility is determined by deducting actual medical expenses in chronological order. Eligibility begins the day the projected nursing home/hospice care billing rate for the remainder of the month is greater than or equal to the remaining spenddown amount.

Budget Period

The budget period for **all** residents of nursing homes or recipients of hospice care applying for ABD Medicaid under AMN is one month.

The **private** pay nursing home/hospice care billing rate is the only medical expense that can be projected.

For an A/R eligible using projected expenses, Medicaid is approved for six month periods if there are no changes anticipated in income or projected medical expense that would affect Medicaid eligibility.

An A/R who is **not** eligible using projected expenses may incur a bill during the month that reduces the spenddown to an amount that can be satisfied by projecting the private pay nursing home/hospice care billing rate for the remainder of the month. If this occurs, Medicaid is approved for one month only, using the day the expense was incurred as the Begin Authorization Date (BAD).

For an A/R eligible as of the first day of the month using projected expenses, patient liability is determined using the same procedures used for recipients approved under the Nursing Home COA.

BASIC CONSIDERATIONS (cont.)

For an A/R eligible using projected and actual expenses, patient liability is determined by allowing **all** medical expenses used to meet spenddown as an IME deduction if they are incurred in the same month for which patient liability is calculated.

PROCEDURES

Follow the steps below to determine AMN eligibility for a nursing home resident or hospice care recipient residing in a nursing home.

Step 1 Determine that the A/R is **ineligible** under the Nursing Home/Hospice Care COA. Refer to **Section 2141, Nursing Home or Section 2135, Hospice Care**.

Step 2 Determine that the A/R meets all basic eligibility criteria, including Level of Care. Refer to **Chapter 2200, Basic Eligibility Criteria**.

EXCEPTION: Length of Stay is **not** a requirement under this COA.

Step 3 Determine resource eligibility. Refer to **Chapter 2500, ABD Financial Responsibility and Budgeting**, and **Chapter 2300, Resources**.

Step 4 Complete an Individual budget to determine the A/R's AMN spenddown amount, using the Medically Needy Income Level (MNIL) for one and a one month budget period. Refer to the **Section 2506, Individual Budgeting.**

Step 5 Project the cost of nursing home/hospice care for the month for which Medicaid eligibility is being determined.

- Use the private pay per diem billing rate for the nursing home/hospice care agency in which the A/R resides/receives services.
- Multiply the per diem billing rate by the number of days the A/R has resided/received services (or is expected to reside/receive services) in the nursing home during the month.

NOTE: Do **not** include days prior to the date of admission or the date of discharge and afterward.

Step 6 Subtract the cost of nursing home/hospice care determined in Step 5 from the A/R's spenddown for the month determined in Step 4.

- If the spenddown is met (there is a deficit), the A/R is eligible from the first day of the month. Proceed to Step 7.
- If a portion of the spenddown remains (there is a surplus), determine eligibility by deducting actual expenses chronologically. Proceed to SPECIAL CONSIDERATIONS in this section.

PROCEDURES (cont.)

Step 7 Approve the A/R on the system for Medicaid from the first day of the first month for which eligibility has been established. In SUCCESS, use code L95 for de facto. For hospice recipients, enter **HP** as the institution type on the **INST** screen, and code the LOC and waiver type codes as **H** as additional indicators that the A/R is a hospice recipient.

- Enter the A/R's total gross income in the system.

NOTE: There is no first day liability (FDL) for this A/R, and Form 400 is **not** required.

Step 8 Determine the A/R's NH patient liability using the procedures used for an A/R determined eligible under the Nursing Home COA. Refer to **Chapter 2559, Patient Liability/Cost Share.** **NOTE:** There is no Cost Share for HC.

NOTE: Do **not** allow the nursing home billing rate projected to meet the spenddown as an incurred medical expense (IME) deduction in the patient liability budget.

Step 9 For AMN NH COA, authorize the vendor payment using the same procedures used for an A/R approved under the Nursing Home COA. Refer to **Section 2576, Vendor Payment Authorization.**

Step 10 Determine whether changes are anticipated in the A/R's income (other than regularly scheduled cost of living adjustments) or nursing home/hospice care billing rate in the next six months that would affect eligibility.

Step 11 If no change is anticipated, complete a review on the case in the sixth month after the month of initial Medicaid approval.

If a change is anticipated, enter an alert in the system to review the case in the month prior to the month of change. Also, complete the special review described above in the sixth month after the month of initial Medicaid approval.

SPECIAL CONSIDERATIONS

Follow the steps below when the projected monthly nursing home/hospice care billing rate does not meet the spenddown **and** the A/R incurs another medical expense(s) during the month.

Step 1 Deduct all allowable medical expenses from the spenddown chronologically by date incurred as they are presented. When any medical expense is deducted, deduct the private pay nursing home/hospice care billing rate per diem that has already been incurred in the month, up through the day prior to the day of the month that the medical expense was incurred.

Step 2 Project the nursing home/hospice care billing rate for the days remaining in the month, beginning with the day the medical expense was incurred.

- If the projection meets the remaining spenddown amount, approve the A/R as Medicaid eligible for the remainder of the month, using the day the expense was incurred as the BAD. Refer to Chart 2151.1, Determining FDL for an AMN Nursing Home Recipient, for procedures on determining the first day liability (FDL) amount and rules on issuing Form 400. Proceed to Step 3
- If the projection does **not** meet the remaining spenddown amount, continue the spenddown process in Step 1.

Step 3 For NH COA, determine the A/R's NH patient liability. Refer to IMEs in Medically Needy Patient Liability Budgets in the Procedures portion of the Section 2555, Incurred Medical Expenses, for rules on allowing the IME deduction in the patient liability budget.

NOTE: Do **not** prorate the A/R's patient liability based on the number of days in the month s/he is Medicaid eligible.

Step 4 For NH COA, authorize the nursing home vendor payment to begin on the BAD. Refer to Special Considerations in Section 2576, Vendor Payment Authorization.

Step 5 Process the case in the system and notify the A/R of vendor payment via system generated notice.

Step 6 Review the case as medical expenses are presented each month to determine whether the A/R can meet the spenddown for the new budget period.

SPECIAL CONSIDERATIONS (cont.)

Use the following chart to determine how to report first day liability (FDL) on an AMN Nursing Home/Hospice Care recipient who meets the spenddown with a combination of projected and actual expenses or only actual expenses. The chart assumes that an expense other than the projected nursing home/hospice care per diem is always applied to the spenddown on the BAD **before** the projected nursing home/hospice care per diem is applied.

Chart 2151.1 - Determining FDL for an AMN Nursing Home/Hospice Care Recipient

IF	THEN
the break-even bill is the projected nursing home/hospice care per diem **AND** the entire amount of a Medicaid covered medical expense incurred on the BAD (other than the nursing home/hospice care per diem) has been applied to meet the spenddown **AND** there are no Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown	Do **not** issue Form 400. Enter the amount of the Medicaid covered expense that was applied in its entirety to meet the spenddown as the FDL on Form 964.
the break-even bill is the projected nursing home/hospice care per diem **AND** the entire amount of a Medicaid covered medical expense incurred on the BAD (other than the nursing home/hospice care per diem) has been applied to meet the spenddown **AND** there are other Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown	Do **not** issue Form 400 for theMedicaid covered expense that was applied in its entirety to meet the spenddown. Issue Form 400 for each of the other Medicaid covered expenses incurred on the BAD that were not applied to the spenddown. Enter a client liability of $0 on each form. Enter the amount of the Medicaid covered expense that was applied in its entirety to meet the spenddown as the FDL on Form 964.
the break-even bill is a Medicaid covered medical expense other than the nursing home/hospice care per diem **AND** there are Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown	Issue Form 400 for the break-even bill. Enter on the form as the client liability the amount of the expense that was applied to the spenddown. Issue Form 400 for each of the other Medicaid covered expenses incurred on the BAD that were not applied to the spenddown. Enter a client liability of $0 on each form. Enter the client liability listed on Form 400 for the break-even bill as the FDL on Form 964.
the break-even bill is a Medicaid covered medical expense other than the nursing home/hospice care per diem **AND** there are no Medicaid covered medical expenses incurred on the BAD other than the expense(s) applied to meet the spenddown.	Issue Form 400 for the break-even bill. Enter on the form as the client liability the amount of the expense that was applied to the spenddown. Enter the client liability listed on Form 400 for the break-even bill as the FDL on Form 964.

Chart 2151.2 - SUMMARY: DEFACTO VS SPENDDOWN		
	DEFACTO	**SPENDDOWN**
Level of Care	Must have a DMA-6(NH) or Hospice Communicator to approve	Same
Length of Stay	Not required	Same
Budget Periods	1 month - May approve for 6 months if no anticipated changes - Do a review 6 months after approval	1 month Approve month by month on Form DMA 964 or on SUCCESS.
Classes of Assistance	SUCCESS: L95	SUCCESS: L99 The FDL is 0.
Projected Expense	Only private pay NH/HC billing rate	Same
BAD	First day of month of eligibility	Date spenddown is met
FDL	$0	Medical bills (other than NH/HC) used to meet SD on BAD
Forms 400 Required	None	See Chart 2151.1
Patient Liability, IMEs, and Income	Only averaged medical expenses not covered by Medicaid (same as regular NH COA A/Rs); do **not** deduct projected NH billing rate used to meet SD. Average income and IMEs.	All medical expenses used to meet SD, including NH/HC private pay per diem incurred prior to BAD each month **NOTE:** If patient liability exceeds DMA billing rate, enter DMA monthly billing rate plus any deductions or IMEs as the patient liability on the SUCCESS "INST" screen. Watch for excess resources. Do **not** average income/IMEs.
Beginning Date of NH VP	Month of admission: DMA-6 payment date if: - eligible, and - in NH, and - no VA contract, OR 1st day of the 1st month of eligibility if not in month of admission	BAD: the date SD is met or DMA-6 payment date, whichever is later

2160 – FAMILY MEDICAID OVERVIEW

POLICY STATEMENT

Family Medicaid provides Medicaid benefits for low income families and individuals who are not receiving SSI and may or may not be receiving TANF. Benefits are provided through a variety of classes of assistance (COA's), each with its own specific eligibility criteria.

BASIC CONSIDERATIONS

Basic Eligibility Criteria

Family Medicaid Assistance Units (AU's) must meet specific Basic Eligibility Criteria:

- age
- application for other benefits
- citizenship/alienage
- cooperation with CSE
- enumeration
- identity
- living with a specified relative
- residency
- third party resources

Each COA has different exceptions to the Basic Eligibility Criteria. Refer to Section 2200, Basic Eligibility Criteria and to each COA in this chapter.

A pregnant woman who is eligible for and receiving Medicaid under any Family Medicaid COA or SSI on the date the pregnancy terminates is eligible to continue to receive 60 days of pregnancy transition Medicaid. The 60-day count begins on the day of the termination of pregnancy. Medicaid continues through the last day of the month in which the 60th day falls.

Medicaid coverage under any Family Medicaid COA or SSI is continued for a pregnant woman who, after approval becomes financially ineligible solely because of new income or a change in income of any BG member. The pregnant woman remains eligible for Medicaid for the remainder of the pregnancy, including the 60-day pregnancy transition. Refer to Section 2720, Continuous Coverage for a Pregnant Woman.

Eligibility for Medicaid in any Family Medicaid COA can begin with the month of application and can include up to three months prior to the month of application. All points of eligibility for that COA must be met in each of the three prior months. Refer to Section 2053, Retroactive Medicaid.

Basic Eligibility Criteria (cont.)	Under certain conditions, Medicaid may cover services rendered to Medicaid-eligible Georgia residents who are out of state when medical services are provided. Procedures for qualifying for out-of-state coverage are found on the back of the Medicaid card.
Financial Eligibility Criteria	All Family Medicaid cases are budgeted using prospective income and expenses. **EXCEPTION**: Eligibility for three months prior Medicaid is determined using actual income and expenses. If available, actual income may be used for intervening months. For Family Medicaid COA's, if resources of the BG are within the applicable resource limit at any time during a month, the AU is resource-eligible for that month. **NOTE:** There is no resource requirement for RSM, TMA and 4MCS COAs. A Family Medicaid case that is ineligible because of financial reasons for one month only is suspended, not terminated. Refer to Chapter 2700, Case Management Overview, Sections 2712, 2714, 2715 and 2716. The parents remain financially responsible for a minor child who lives with them, even if the child is married, divorced or widowed. **EXCEPTION**: If a pregnant minor applies for RSM PgW, her parents' income is not considered in determining RSM eligibility.
OTHER CONSIDERATIONS:	Family Medicaid applications are accepted at the following sites: • county DFCS offices • RSM Project or DFCS outreach locations • Public health departments • Public medical facilities • Federally funded health care centers • disproportionate-share hospitals Refer to Section 2050, Application Processing.

Presumptive Eligibility

Presumptive Eligibility (PE) is determined by Qualified Providers (QPs) certified by the Division of Medical Assistance (DMA). PE is a temporary eligibility determination and is available only to pregnant women to cover the cost of prenatal care. If the pregnant woman is determined eligible for PE, a temporary Medicaid Certification is issued by the QP. An abbreviated RSM application and other forms are completed concurrently and routed to DFCS for processing. In some counties, the application is completed by a Right From the Start Medicaid (RSM) Project outreach worker. Refer to Sections 2050, Application Processing and 2184, RSM Pregnant Woman for additional information regarding PE.

PROCEDURES

The Medicaid application process begins with a request for assistance and ends with notification to the AU of the eligibility decision. Refer to Section 2050, Application Processing for additional information.

A **Continuing Medicaid Determination** (CMD) is required before denying a Medicaid application or terminating Medicaid under the current COA. A CMD is the determination of Medicaid eligibility under all COA's. Refer to Section 2050, Application Processing and Section 2700, Ongoing Case Management for additional information.

At application and review, contact the A/R to inquire if any AU member is pregnant. If an AU member is pregnant, schedule a follow-up contact with the pregnant woman during the month prior to the **Estimated Delivery Date** (EDD).

Referrals

Refer all Medicaid recipients under age 21 to the county health department for health check services. Refer to Section 2700, Referrals for additional information.

Refer the following to the county health department for services under the **Women, Infant and Children** (WIC) **Program:**

- pregnant women
- women who are breast feeding through the first twelve months after the birth of a child
- children under age five
- post-partum women for six months from the termination of pregnancy

Refer to Section 2985, WIC Services for additional information.

2162 - LOW INCOME MEDICAID

POLICY STATEMENT

Low Income Medicaid (LIM) provides Medicaid benefits for children up to age 18 and adults who are not receiving Supplemental Security Income (SSI). LIM individuals may or may not be receiving Temporary Assistance to Needy Families (TANF).

BASIC CONSIDERATIONS

Basic Eligibility Criteria

LIM AU members must meet the following basic eligibility requirements:

- **Age**

  A child must be under the age of 18 to be eligible for LIM. There is no age requirement for adult AU members. Refer to Section 2255, Age.

- **Application for Other Benefits**

  The A/R must apply, or agree to apply for and accept other benefits to which s/he or other AU members may be entitled.

  A parent who does not meet this requirement and those children for whom the parent is responsible are excluded from the AU. A non-parent relative or a child for whom this requirement is not met is excluded from the AU.

  Refer to Section 2210, Application for Other Benefits.

- **Citizenship/Alienage**

  Each AU member must be U.S. citizen or meet alien eligibility requirements. Refer to Section 2215, Citizenship/Alienage.

- **Enumeration**

  The A/R must furnish, apply for, or agree to apply for a Social Security Number (SSN) for each AU member, unless Good Cause is established.

  A parent who does not meet this requirement, without Good Cause, is penalized. A non-parent relative or a child for whom this requirement is not met, without Good Cause, is excluded from the AU.

  Refer to Section 2220, Enumeration.

Basic Eligibility Criteria (cont.)

- **Child Support Enforcement (CSE)**

  The AU must cooperate with CSE in the attempt to obtain medical support from the absent parent (AP), unless Good Cause is established. A referral to, and cooperation with Child Support Enforcement (CSE) is, however **NOT** a requirement for child-only Medicaid cases.

  A child-only Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid under the same case as the child or under any related case. An AU which contains a penalized adult is **NOT** considered a child-only case.

  NOTE: The AP of a child included in a LIM AU is not referred to CSE if the AP provides health insurance for the child, unless the A/R wishes to pursue collection of child support monies.

  A parent who does not cooperate with CSE, without Good Cause, is penalized. A non-parent relative who does not meet this requirement, without Good Cause, is excluded from the AU.

  Refer to Section 2250, Cooperation with CSE.

- **Living With a Specified Relative**

  A child must be related to and living in the home with a specified relative in order to be included in the AU.

  NOTE: Legal guardianship does not meet the relationship requirement. When a child lives with an unrelated legal guardian, eligibility for the child must be determined under RSM Child COA.

  Refer to Section 2245, Living with a Specified Relative.

- **Residency**

  LIM AU members must be residents of Georgia.

  Refer to Section 2225, Residency.

Basic Eligibility Criteria (cont.)	• **Third Party Resource Requirements** The LIM A/R is required to provide information regarding any Third Party Resources (TPR) available to any AU member. The A/R must assign his/her TPR rights to DMA, unless Good Cause exists. A parent who does not meet this requirement, without Good Cause, is penalized. A non-parent relative who does not meet this requirement, without Good Cause, is excluded from the AU. Refer to Section 2230, Third Party Resources.
Financial Eligibility Criteria	LIM AU's total countable resources must be equal to or less than the LIM resource limit. Refer to Chapter 2300, Resources and Appendix A2, Financial Limits for Family Medicaid. LIM AU's must have income within the following limits: • **Gross Income Ceiling (GIC)** The gross countable income of the LIM AU must be equal to or less than the GIC for the AU size. • **Standard of Need (SON)** The net countable income of the LIM AU must be less than the SON for the AU size. For income limits, refer to Appendix A2, Financial Limits for Family Medicaid. Refer to Chapter 2650, Family Medicaid Budgeting.

Financial Eligibility Budgeting

Prospective budgeting is used in determining LIM eligibility for the application month and the ongoing benefit period. If available, actual income may be used for intervening months.

Actual income is used in determining LIM eligibility for prior months.

Income is deemed from a non-AU member to an AU member for whom the deemor is financially responsible.

Income may be allocated from a LIM AU member to his/her ineligible spouse and/or ineligible child.

LIM income deductions include the following:

- $90 standard work expense deduction
- $30 earned income deduction
- 1/3 deduction of the remaining earned income
- $50 child support deduction
- dependent care deduction (amount is dependent upon the age of the child)

The $30 + 1/3 deduction is not used if it is not needed in order for the AU to be eligible.

Refer to Chapter 2650, Family Medicaid Budgeting.

2166 - TRANSITIONAL MEDICAL ASSISTANCE (TMA)

POLICY STATEMENT

Transitional Medical Assistance (TMA) provides continued Medicaid coverage for up to 12 months for Low Income Medicaid (LIM) Aus that become ineligible because of changes related to earned income.

BASIC CONSIDERATIONS

To be eligible for continued Medicaid coverage under TMA, the AU must have correctly received LIM in three of the six months preceding the first month of LIM ineligibility.

To be eligible for continued Medicaid coverage under TMA, LIM ineligibility must result from one of the following reasons:

- New or increased earnings of an adult AU member

  Increased earnings includes any of the following
  - new employment
  - increase in earnings as a result of an increase in hours worked
  - increase in salary or hourly wage
  - earnings of an eligible adult added to the LIM AU

- the expiration of the four month $30 + 1/3 earned income deduction for an AU member

- the expiration of the eight month $30 earned income deduction for an AU member

An AU is **ineligible** for TMA if any one of the following resulted in ineligibility for LIM:

- receipt of a non-recurrent bonus or vacation pay

- decrease in child care expenses

Cooperation with Third Party Resources (TPR) is required at approval for TMA as well as during both 6-month review periods. Refer to Section 2230, Third Party Resources.

Referral to Child Support Enforcement is not required.

BASIC CONSIDERATIONS (cont.)

TMA AU

The TMA AU is available **only** to the individuals whose needs were included in the AU at the time of LIM ineligibility because of increased earnings.

Any individual who moves into the home during the TMA eligibility period is ineligible for TMA, however s/he may qualify for another Medicaid COA.

EXCEPTION: If the individual who moves into the home was previously a member of the TMA AU, the individual may be added.

Eligibility Period

An AU is potentially eligible to receive TMA for 12 months, beginning with the first month following the last month of LIM eligibility. The last month of LIM is the 1st or 2nd month after the financial change occurs, depending on the effective date of the change, when the worker takes action based on the change and the expiration of timely notice.

The AU must report the increase in earned income within 10 days of receiving the income. If the AU fails to report the change within 10 days of receipt of the increase, the eligibility worker (EW) must determine when the change should have been effective, based on the 10 day reporting requirement.

The TMA period of eligibility consists of the following:

- the initial 6-month extension
- an additional 6-month extension.

Each of the 6-month periods has specific and distinct eligibility requirements.

Financial Eligibility

There is no income requirement for the first 6 months of TMA eligibility. To remain eligible for the second 6 months of TMA, the AU's income must be below 185% of the Federal Poverty Level (FPL).

There is no resource requirement for TMA.

Allowable child care costs are limited to those necessary for the employment of the caretaker or other adult AU member(s).

Reporting

To remain eligible for TMA, the AU must report gross income on a quarterly basis. The Quarterly Report Form (QRF) is mailed by the agency to the AU.

BASIC CONSIDERATIONS

Reporting (cont.)

During the initial 6-month TMA eligibility period, if the AU does not comply with QRF requirements for the QRF due in the 4th month, TMA eligibility terminates effective the first month after the initial extension (7th month).

If the AU does not comply with QRF requirements for the QRF due in the 7th month, eligibility terminates effective the 8th month.

If the AU does not comply with QRF requirements for the QRF due in the 10th month of TMA, eligibility terminates effective the 11th month.

Initial Six Months Extension

To be eligible to **begin** the **initial** six months of TMA, the AU must meet **ALL** of the following requirements:

- must be financially ineligible for LIM based on one of the reasons listed previously in this Section
- must have correctly received LIM during three of the six months preceding the first month of LIM ineligibility
- must include a child under 18 years of age

Additional Six Months Extension

To be eligible to **begin** the **additional** six month extension the AU must meet **ALL** of the following requirements:

- must have received TMA for each month of the initial six month extension
- must have met the reporting requirement in the 4th month of TMA
- must include a child under 18 years of age.

To **remain** TMA eligible for the additional six-month extension, the AU must meet **ALL** of the following requirements:

- must comply with the 7th and 10th month reporting requirements by providing a completed QRF by the 5th day of the 7th and 10th months of TMA
- must meet TMA income eligibility requirements
- must include the caretaker or other eligible adult who was employed for at least part of each of the months included in the 7th and 10th months QRFs.

  NOTE: Any eligible adult in the AU can meet the employment criteria, even if s/he was not employed when the AU became eligible for TMA. Employment, for TMA purposes, is defined as working during the month. Receipt of a remaining paycheck from previous employment does not meet this criterion.

BASIC CONSIDERATIONS

Additional Six Months Extension (cont.)

- must include a child under 18 years of age

EXCEPTION: If the only child in the TMA AU becomes eligible for SSI, the other AU members may continue to receive TMA until the child is 18 years of age, or until the end of the TMA period if all of the above is met, whichever occurs first.

Good Cause

Good Cause may be claimed for unemployment during one or more of the specified months. Refer to Special Considerations in this section.

If the TMA case is terminated because of unemployment of the caretaker or other eligible adult, without Good Cause, TMA cannot be reinstated, even if employment is subsequently obtained.

If TMA is terminated because of excess earnings, it cannot be reinstated, even if the AU's countable income later falls below the TMA income limit. The A/R may, however, reapply for LIM. If LIM is approved and subsequently terminated, TMA eligibility may be approved only if the LIM termination qualifies the AU for a new period of TMA.

PROCEDURES

Initial Six Month Extension

Follow the steps below to establish the initial six month extension of TMA.

Step 1 Establish that the AU is financially ineligible for LIM based onl the criteria listed previously in this Section.

Step 2 Establish that the AU correctly received LIM in three of the six months preceding the first month of LIM ineligibility. Refer to Section 2162, Low Income Medicaid.

Step 3 Determine the last month of LIM, based on the date of the change, date the caseworker took action and the expiration of timely notice. If the AU fails to report the change within 10 days of receipt of the increase, determine when the change should have been effective, based on the 10-day reporting requirement.

Step 4 Notify the AU of the following:

- termination of LIM eligibility
- approval of the initial six months of TMA
- reporting requirements of continued TMA eligibility

PROCEDURES
Initial Six Month Extension (cont.)

Step 5 Mail QRF (if sent manually, Form 328) by the 15th of the third month of TMA. The QRF must request the AU's actual gross income and child care expenses paid, if any, for the first, second and third months of TMA.

NOTE: The AU may provide this information verbally or in writing other than on the QRF. AU statement is acceptable verification unless questionable.

Step 6 Use Chart 2166.1, Processing QRF Due in the Fourth Month of TMA to process the QRF or information received, or to determine the appropriate action to be taken if the QRF or information is not received.

Additional Six Month Extension Follow the steps below to continue eligibility for the additional six month extension of TMA.

Step 1 Send QRF by the 15th day of the sixth month of TMA if the recipient complied with fourth month reporting and received all six months of TMA during the initial extension. Request gross income and child care expenses paid for the fourth, fifth and sixth months of TMA.

NOTE: AU statement of earnings and childcare expenses is accepted, unless questionable. The QRF is due by the 5th day of the seventh month.

Step 2 Complete TMA budgeting procedures in the seventh month after the QRF is returned by the AU. Refer to Section 2667, TMA Budgeting and Chart 2166.2, TMA QRF Processing for the Seventh and Tenth Months.

If the AU remains eligible based on the TMA budget, continue TMA.

If the AU is TMA ineligible because of earnings reported on the QRF, or if ineligible for any other reason, complete a CMD prior to termination of TMA and notify the AU.

Step 3 Send QRF by the 15th day of the ninth month of TMA if the recipient complied with the seventh month QRF. Request gross income and child care expenses paid for the seventh, eighth and ninth months of TMA.

NOTE: AU statement of earnings and childcare expenses is accepted, unless questionable. The QRF is due by the 5th day of the tenth month.

PROCEDURES
Additional Six Month Extension (cont.)

Step 4 Complete TMA budgeting procedures in the tenth month after the QRF is returned by the AU. Refer to Section 2667, TMA Budgeting and Chart 2166.2, TMA QRF Processing for the Seventh and Tenth Months.

If the AU remains eligible based on the TMA budget, continue TMA.

If the AU is TMA ineligible because of earnings reported on the QRF, or if ineligible for any other reason, complete a CMD prior to termination of TMA and notify the AU.

Step 5 Complete a CMD during the 12th (final) month of TMA eligibility and notify the AU prior to termination of TMA.

TMA SPECIAL CONSIDERATIONS

Procedures to Determine if a QRF is Complete

Use the following criteria to determine if a QRF is complete:

- The QRF is signed by the recipient and dated on or after the last day of the last month for which information is being reported.

  NOTE: If the QRF is unsigned, it is incomplete. Return for a signature. If the QRF is dated prior to the last day of the last month for which information is being reported, it is incomplete. Return for correction.

- All items except Question No. 3 are completed. All **yes/no** blocks are checked. (Question No. 3 is used only for a continuing Medicaid eligibility determination if the family is ineligible for TMA.)

  NOTE: Fourth month QRF requirements may be met verbally or in writing other than on the QRF.

- AU statement of earnings and child care expenses reported on the QRF, due in the seventh and tenth months, is accepted unless questionable.

  NOTE: If the QRF is incomplete, obtain the information through telephone contact, in writing or in person. Document the contact.

Procedures to Determine Good Cause for Failure to Meet Work Requirements

Use the following information to determine if Good Cause exists for failure to meet the work requirements because of the termination of employment of a caretaker or other eligible adult:

- Explore the reason for termination of employment with the A/R.
- Use the following list as examples in determining if Good Cause exists. This list is not inclusive.
  - involuntary loss of employment, e.g., layoff
  - illness of the recipient or an immediate family member
  - family emergency
  - child care not available
  - transportation not available

  NOTE: If Good Cause exists, the reporting requirement is met. Obtain the information needed to determine continued eligibility.

Document the case decision.

Procedures to Determine Good Cause for Failure to Comply with QRF Requirements

Good Cause for untimely or incomplete submission of QRFs may be granted.

The following are examples of Good Cause. This list is not inclusive.

- The recipient did not receive the QRF or received it untimely.
- The recipient or an immediate family member was ill or in the hospital.
- The recipient is illiterate.
- There was a serious family crisis such as death.
- There was a natural disaster.
- The recipient was out of town.
- The return envelope was postmarked in time to reach the county department but did not. The QRF is considered timely if postmarked at least one day prior to the deadline.
- The AU was ineligible for TMA when the report was due but the reason for ineligibility no longer exists. This is applicable only to AUs who were ineligible for TMA because of any of the following reasons:
  - the AU moved out of state
  - the only child ceased to live with the family
  - the individual who qualified the AU for TMA ceased to live with the AU.

  NOTE: If Good Cause exists, the reporting requirement is met. Obtain the information needed to determine continued eligibility.

  Document the decision.

Use the following chart to process the QRF due in the fourth month of TMA:

CHART 2166.1, PROCESSING QRF DUE IN FOURTH MONTH OF TMA	
IF	**THEN**
The completed QRF is received by the 5th calendar day	Begin the additional six month extension of TMA in the seventh month.
The QRF is not received by the 5th calendar day of the fourth month of TMA (or by the next work day if the 5th falls on a weekend or holiday)	Send TMA Quarterly Report Follow-up Notice, giving the AU until the 21st to provide the completed QRF or the information requested on the form.
The completed QRF or information is received by the 21st	Begin the additional six month extension of TMA in the seventh month.
The QRF or the information requested is not received by the 21st	Determine if Good Cause exists. Refer to Special Considerations in this section.
Good Cause does not exist	Terminate TMA effective the seventh month of eligibility after completing a CMD. Provide adequate notice.
The QRF or information is received prior to the 21st but is incomplete.	Send a second TMA Quarterly Follow-up Notice within 5 calendar days. Allow an additional 10 days or until the 21st, whichever is later, to provide the needed information.
The completed QRF or the information requested is received by the second deadline.	Begin the additional six month extension of TMA in the seventh month.
The completed QRF or the information requested is not received by the second deadline.	Terminate TMA effective the seventh month of eligibility after completing a CMD. Allow adequate notice.
The QRF is timely for the second deadline but is incomplete.	Send a third TMA Quarterly Follow-up Notice. Allow an additional 10 days for response. • If the completed QRF or needed information is received by the extended deadline, the report requirement is met. • If the completed QRF or needed information is not received by the extended deadline, take action to terminate TMA effective the 7th month with adequate notice.

NOTE: Refer to Special Considerations for information on determining if a QRF is complete and determining Good Cause for not complying with reporting requirements.

Use the following chart to process the QRFs due in the seventh and tenth months of TMA.

CHART 2166.2, TMA QRF PROCESSING PROCEDURES FOR THE SEVENTH AND TENTH MONTHS	
IF	**THEN**
The completed QRF is received by the 5th calendar day of the seventh or tenth month.	Continue TMA eligibility.
The QRF is not received by the 5th calendar day of the report month or by the next work day if the 5th falls on a weekend or holiday.	Send TMA Quarterly Report Follow-up Notice, giving the AU until the 21st to provide the completed QRF.
The completed QRF is received by the 21st.	The reporting requirement is met. Continue TMA eligibility.
The QRF is not received by the 21st.	Determine if Good Cause exists.
Good Cause does not exist.	Terminate TMA effective the eight or eleventh month of TMA after completing a CMD. Provide adequate notice.
The QRF is received prior to the 21st but is incomplete.	Send a second TMA Quarterly Report Follow-up Notice. Allow an additional 10 days or until the 21st, whichever is later.
The completed QRF is received by the second deadline.	The reporting requirement is met. Continue TMA eligibility.
The completed QRF is not received by the second deadline.	Terminate TMA effective the eight or eleventh month after completing a CMD. Provide adequate notice.
The QRF is timely for the second deadline but is incomplete.	Send a third TMA Quarterly Report Follow-up Notice. Allow an additional 10 days for response. • If the completed QRF is received by the extended deadline, the reporting requirement is met. Continue TMA eligibility. • If the completed QRF is not received by the extended deadline, terminate TMA effective the eight or eleventh month after completing a CMD. Provide adequate notice.

NOTE: Refer to Special Considerations in this Section for information on determining if a QRF is complete and determining good cause for not complying with reporting requirements.

2170 - FOUR MONTHS EXTENDED MEDICAID BECAUSE OF CHILD SUPPORT INCOME

POLICY STATEMENT

Four Months Extended Medicaid Because of Child Support (4MCS) provides 4 months of Medicaid coverage for a LIM AU which has become ineligible because of the receipt of child support.

BASIC CONSIDERATIONS

4MCS is available to an AU that becomes ineligible for LIM because of an increase in child support or a concurrent increase of child support and other income.

An AU with earned income that becomes ineligible for LIM because of concurrent increase child support and earned income has the option of receiving TMA or 4MCS. It is, however to the AU's advantage to receive TMA instead of 4MCS if earned income exists because:

- TMA eligibility period is up to 12 months as opposed to the 4 month 4MCS eligibility period
- if the AU elects to receive 4MCS and subsequently becomes ineligible, Medicaid cannot be reinstated under TMA.

The AU must have correctly received LIM in three of the six months preceding the first month of LIM ineligibility. Refer to Section 2162, LIM for criteria for correctly receiving LIM.

LIM ineligibility may be caused by an increase in child support and a concurrent change. If the concurrent change alone caused LIM ineligibility, the AU is ineligible for 4MCS.

Increased child support is defined as any of the following:

- the initial receipt of child support
- an increase in the amount of child support received
- the receipt of an additional child support payment.

If the AU receives a back payment of child support, the lump sum is budgeted as income in the month of receipt unless the accumulation is because of an administrative procedure or error.

The child support may be received directly from the absent parent (AP), through CSE or another source such as Clerk of the Court.

If LIM ineligibility results when adding a child with child support to a LIM AU, 4MCS can be approved for the entire AU.

BASIC CONSIDERATIONS (cont.)

Reporting

The AU must report the increase in child support within 10 days of receiving the income. If the AU fails to report the change within 10 days of receipt of the increase, the eligibility worker (EW) must determine when the change should have been effective based on the 10 day reporting requirement.

The EW must make the change as soon as possible, but no later than 10 days after the report. If LIM ineligibility results from the increase in child support income, 4MCS eligibility begins the first month following the expiration of timely notice.

Ongoing Eligibility

Once 4MCS eligibility is established, the AU does not have to continue to receive child support in each of the four months to remain eligible.

A notice is sent at the beginning of the four month extended period specifying the months of eligibility under 4MCS. No notice is required at the end of the four month period.

An AU that becomes eligible for LIM during the 4MCS eligibility period has the option of receiving LIM or 4MCS. If the AU elects to receive LIM and subsequently becomes ineligible, Medicaid cannot be reinstated for the remainder of the original 4MCS period. However, if the reason for LIM ineligibility would again qualify the AU for 4MCS, a new 4MCS eligibility period may be established.

4MCS is available **only** to the individuals whose needs were included in the AU at the time of LIM ineligibility because of the receipt of child support. Any individual who moves into the home during the 4MCS eligibility period is **ineligible** for 4MCS, however s/he may qualify for another Medicaid COA.

EXCEPTION: If the individual who moves into the home was previously a member of the 4MCS AU, the individual **may** be added. Refer to Chart 2170.1 in this section.

PROCEDURES

Follow the steps below to establish Medicaid eligibility for the AU under 4MCS.

Step 1 Determine the amount of child support, the date of first receipt and the date reported by the AU.

Step 2 Complete a budget indicating LIM ineligibility because of child support income or child support income in combination with other income, but not the other income alone.

Step 3 Establish that the AU correctly received LIM in three of the six months preceding the first month of ineligibility for LIM.

Step 4 Terminate LIM and approve 4MCS for the AU effective the month following the expiration of timely notice.

Step 5 Notify the A/R of the change, specifying the four months of Medicaid eligibility under 4MCS and the individuals covered.

Step 6 At the end of the four month eligibility period, complete a CMD and notify the AU.

Use the following chart to determine the action to be taken because of changes in the AU during the Four Months Extended Medicaid time period.

CHART 2170.1, CHANGES IN AU DURING FOUR MONTHS EXTENDED MEDICAID		
IF	**THEN discontinue 4MCS for**	**AND reinstate 4MCS effective**
the individual whose income qualified the AU for 4MCS leaves the home **OR** the only child in the AU leaves the home	the entire AU and complete a CMD. **NOTE:** If the only child leaves the home, provide a copy of the Medicaid Certification to the adult with whom the child is now living while a CMD is being completed. Use the existing case number during this time.	the month after the individual returns, if there are months remaining on the original 4MCS time period and all eligibility requirements are met.
any other AU member leaves the home	the individual leaving the AU	the month that the individual returns to the AU, only if there are months remaining in the original 4MCS eligibility period.
the entire AU leaves Georgia	the entire AU	the month following the month the AU returns to the state if there are months remaining on the original MAO time period.
the only child in the AU reaches age 18	the entire AU. Complete a CMD.	N/A

2172 - LIM INDIVIDUALS IN A NURSING HOME

POLICY STATEMENT	LIM Individual in a Nursing Home (LIM-NH) provides Medicaid to an individual who is temporarily receiving treatment in a nursing facility.
BASIC CONSIDERATIONS	A member of a LIM AU who is temporarily receiving treatment in a nursing facility remains eligible for Medicaid. An approved level of nursing home care (skilled, intermediate or intermediate care for the mentally retarded) must be obtained from the Georgia Medical Care Foundation (GMCF) before DMA will assume the cost of nursing home care. Level of care is obtained by sending Form DMA-6 completed by the physician to GMCF for a level of care approval. This process is initiated by the nursing home when the LIM individual is admitted for care. The eligibility worker (EW) determines whether the nursing home placement will be temporary or permanent. This decision should be based on the length of stay indicated on the DMA-6, statements from family members, the nursing facility, physician, etc. and any other information available to the EW. Generally, any nursing home admission with an expected duration of less than six (6) months is considered temporary. • If the care is expected to be temporary, the individual may remain in the original LIM AU. • If the care is expected to be permanent, remove the individual from the LIM AU and determine eligibility under an ABD Medicaid COA.

PROCEDURES

Follow the steps below to determine Medicaid eligibility of a LIM AU member who is temporarily in a nursing facility.

Step 1 Determine whether the expected duration of the nursing home placement will be temporary or permanent. Refer to Chart 2172.1 to determine appropriate action.

CHART 2172.1, REQUIRED ACTION BASED ON DURATION OF PLACEMENT

IF THE	THEN
admission is expected to be temporary (generally, less than 6 months)	determine eligibility for LIM of the individual in the nursing home as if s/he were in the family home. Approve vendor payment for the nursing facility. Notify the AU, the nursing facility and DMA. No income shall be applied to the billing rate or maximum vendor payment.
admission is expected to be permanent (generally, longer than 6 months)	remove the individual from the LIM AU. Complete an eligibility determination under ABD Medicaid and authorize a nursing home vendor payment, if eligible.
Individual in the nursing home becomes SSI eligible	Remove the individual from the LIM AU and authorize a nursing home vendor payment under an ABD Medicaid COA.

PROCEDURES (cont.)

Step 2 Inform the applicant and/or responsible party of the SSI program possibility for the individual in the nursing home.

Step 3 Document the case decision in the LIM record.

2174 - NEWBORN MEDICAID

POLICY STATEMENT

Newborn (NB) Medicaid provides Medicaid coverage to a child born to a mother who was eligible for and receiving Medicaid in Georgia on the day the child was born.

BASIC CONSIDERATIONS

A child is eligible for Newborn Medicaid for up to 13 months beginning with the month of birth and continuing through the month in which the child reaches age 1, as long as the child lives with the mother continuously. Eligibility begins with the birth month, regardless of when the agency is notified of the birth.

Receiving Medicaid

A child is eligible for Newborn Medicaid if born to a mother eligible for and receiving Medicaid under any class of assistance (COA), including Supplemental Security Income, any Aged, Blind and Disabled COA or to a mother receiving Emergency Medical Assistance.

EXCEPTION: A child born to a woman who is in Medically Needy suspense status on the day of delivery is ineligible for NB Medicaid. Spenddown must be met on or before the date of delivery for the child to qualify for NB.

Eligible for and receiving Medicaid is defined as follows:

- The mother's Medicaid application was filed and approved prior to the birth of the child.

OR

- The mother's application for Medicaid was filed prior to the birth of the child, approved after the birth of the child, and the approval covered the date the child was born.

OR

- The mother's application for Medicaid was filed and approved after the birth of the child and the approval covered the date the child was born.

BASIC CONSIDERATIONS (cont.)

Living Arrangements

The child meets the requirements of living with the mother for the following month(s):

- the month of birth and subsequent months, as long as the child lives in the home with the mother continuously,
- the month of birth, even if the child is placed in foster care or is relinquished for adoption, or if the child dies during the first month
- the month of birth and subsequent months when the child is continuously hospitalized from birth, as long as the mother has not relinquished control of the child or the state has not determined that the child has been abandoned.

Request for Newborn Medicaid Coverage

The request for Newborn Medicaid may be made by the mother or the Medicaid provider. The request may be made by contacting DFCS in person, by telephone or in writing. The provider may also request Newborn Medicaid by contacting the Division of Medical Assistance (DMA) through DMA's fiscal agent, Electronic Data Systems (EDS), or by contacting a DFCS Change Center.

When the request for Newborn Medicaid is made by the mother or the provider, coverage is approved effective the month of birth. To continue Medicaid beyond the month of birth, the child's ongoing living arrangements must be established. The mother's statement of the child's living arrangements is acceptable, unless questionable.

When the provider contacts DMA directly to request Newborn Medicaid for a child, DMA will approve the child on their system and assign a temporary Medicaid number ending in N. DMA provides DFCS with a monthly listing of children that have been added to their system.

Upon notification by DMA, that the child has been added to their system, the mother must be contacted and the child's ongoing living arrangements established prior to approval of NB Medicaid.

Neither an application nor an interview is required to approve a child for Newborn Medicaid.

BASIC CONSIDERATIONS (cont.)

Dual Eligibility

A child who is dually eligible for Newborn Medicaid and another Medicaid COA may be approved for either COA.

The agency must evaluate the family's circumstances to determine which Medicaid COA provides coverage to the maximum number of family members for the maximum length of time.

If a Newborn Medicaid eligible child receives Medicaid under another COA and becomes ineligible during any month up to and including the month the child turns 1, NB coverage can be approved for the remainder of the thirteen months, provided NB requirements have been met continuously since birth.

Ongoing Eligibility

The child does not have to meet any financial or non-financial eligibility requirements other than to live with the mother in Georgia in order to continue to receive Newborn Medicaid after the month of birth.

The **only** circumstances under which a child may become ineligible for Newborn Medicaid are as follows:

- the child no longer lives with the mother
- the child no longer lives in Georgia.

If the child becomes ineligible for Newborn Medicaid for one of these two reasons, the child's eligibility under this COA can never be reinstated.

The mother is required to report within 10 calendar days any changes, which may affect the child's eligibility for Newborn Medicaid.

Periodic reviews are not required.

Child Support Enforcement

The absent parent of a child receiving Newborn Medicaid is not referred to Child Support Enforcement (CSE). However, the mother must be advised that CSE services are available to her. If the mother is interested in receiving these services, she must be provided with written information on how to contact the local CSE office. Refer to Section 2250, Child Support Enforcement.

BASIC CONSIDERATIONS (cont.)

Third Party Resources

The mother of a child receiving newborn Medicaid is not required to provide information on third party resources available to the newborn. However, the agency must inquire about third party resources and submit any information obtained to DMA. Refer to Section 2230, Third Party Resources.

Continuing Medicaid Determination

A Continuing Medicaid Determination (CMD) must be completed in the last month of Newborn Medicaid eligibility.

Requirements for completion of the CMD are dependent on the information already known to the agency because of concurrent Medicaid, TANF or Food Stamp eligibility of other family members.

The CMD may require a complete review of eligibility, including a face-to-face contact, or may require only a telephone contact. The worker must evaluate the available information to determine the extent of the contact required. Refer to Section 2052, Continuing Medicaid Determination.

If the child is not eligible for Medicaid under any COA, a PeachCare for Kids application and information on the PeachCare for Kids program must be provided to the family.

PROCEDURES

Follow the procedures below when notified of the birth of a child.

- Establish that the mother was eligible for and receiving Medicaid on the day the child was born.
- Establish the child's ongoing living arrangements by contact with the mother.
- Approve Newborn Medicaid for the child on the system.
- Continue Newborn Medicaid for the child if s/he continues to live with the mother.
- Terminate Newborn Medicaid following timely notice at any time the child ceases to live with the mother or ceases to live in Georgia.

PROCEDURES (cont.)	
Continuing Medicaid Determination	Complete a CMD in the last month of Newborn Medicaid eligibility. If the child is not eligible for Medicaid under any COA, provide the AU with a PeachCare for Kids application and information on the PeachCare for Kids program.
DOCUMENTATION AND VERIFICATION	Establish the mother's Medicaid eligibility for the month of the child's birth by agency records or by the State Data Exchange for a SSI recipient. Accept the mother's or the Medicaid provider's statement of the child's date of birth, unless questionable. Accept the mother's statement of the child's living arrangements unless questionable. If questionable, refer to Section 2245, Living with a Specified Relative for methods of verification. Document the following information in the case record: • the child's name and date of birth, • the Medicaid eligibility status of the mother, • the mother's statement of the child's living arrangement after the month of birth.

2180 - RIGHT FROM THE START MEDICAID OVERVIEW

POLICY STATEMENT

Right from the Start Medicaid (RSM) provides Medicaid to eligible children through the month in which the child turns 19 years of age and to pregnant women who meet RSM eligibility criteria. Income limits for this COA are based on percentages of the Federal Poverty Level (FPL).

BASIC CONSIDERATIONS

Because of the less restrictive program requirements, Medicaid applicants who are RSM eligible should be approved under RSM, regardless of their eligibility under another Medicaid COA, with the following exceptions:

- Newborn Medicaid
- Low Income Medicaid (LIM)
- Work Transition Medicaid (WTM)
- Transitional Medical Assistance (TMA)
- Four Months Extended Medicaid because of Child Support Income (4MCS)
- IV-E Foster Care

Basic Eligibility Criteria

The following basic eligibility requirements must be met to qualify for RSM:

- Age

  EXCEPTION: There is no age requirement for pregnant women. A RSM child can be eligible through the last day of the month of the nineteenth (19^{th}) birthday. A Child Welfare Foster Care (CWFC) child may be eligible until age 21.

  Refer to Section 2255, Age.

- Application for Other Benefits

  EXCEPTION: Application for SSI is not required. Application for other benefits is not a requirement for RSM PgW coverage.

  NOTE: If a pregnant woman is receiving Medicaid in a LIM AU and does not comply with Application for Other Benefits, she may receive Medicaid under RSM-PgW COA in which Application for Other Benefits is not a requirement.

  Refer to Section 2210, Application for Other Benefits.

BASIC CONSIDERATIONS

Basic Eligibility Criteria (cont.)

- Enumeration

  NOTE: Enumeration is not a requirement for Emergency Medical assistance (EMA). Refer to Section 2054, EMA.

  Refer to Section 2220, Enumeration.

- Citizenship/Alienage

  NOTE: Citizenship/alienage is not a requirement for Emergency Medical Assistance (EMA). Refer to Section 2054, EMA.

- Residency

  Refer to Section 2225, Residency.

- Third Party Resources

  NOTE: This includes TPR information on the reputed or legal father of an existing child.

  Refer to Section 2230, TPR.

- Cooperation with Child Support Enforcement (CSE)

  EXCEPTION: A referral to, and cooperation with CSE is **NOT** a requirement for child-only Medicaid cases.

  A child-only Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid under the same case as the child or under any related case. An AU which contains a penalized adult is **NOT** considered child-only case.

  Refer to Section 2250, Child Support Enforcement.

BASIC CONSIDERATIONS (cont.)

Financial Eligibility Criteria

Resources are not considered in determining eligibility for RSM.

RSM income limits are based on percentages of the FPL. Refer to Appendix A2, Financial Limits for Family Medicaid.

The income of a person not included in the RSM BG (such as, but not limited to stepparents, parents of a pregnant minor who is budgeted as an adult, parents of a minor caretaker or children voluntarily excluded) is not budgeted.

Verification

Client statement of income and child care expenses is acceptable verification, unless questionable.

Other Considerations

A pregnant minor in a RSM case can be budgeted as an adult pregnant woman or as a minor child. If budgeted as a minor child, do not budget the unborn child.

2182 – RSM CHILD

POLICY STATEMENT

RSM Child Medicaid provides Medicaid to children from birth through the last day of the month in which the child turns nineteen (19) years of age.

BASIC CONSIDERATIONS

RSM coverage is available to the following children:

- a child from birth through the last day of the month of the first (1st) birthday. Countable income must be less than or equal to 185% of the FPL. This applies to children who are ineligible for Newborn Medicaid.
- a child age one (1) through the last day of the month of the 6th birthday. Countable income must be less than or equal to 133% of the FPL.
- a child age six (6) through the last day of the month of the 19th birthday. Countable income must be less than or equal to 100% of the FPL.

The applicant's statement of the child's date of birth may be acceptable.

For RSM Child purposes, an 18 year old is considered a minor child and remains the financial responsibility of his/her parent(s). Spouse-to spouse deeming and allocation of income apply for married minors.

Eligibility for RSM Child may continue through the month the child reaches age 19. Assistance may continue if the child is receiving inpatient medical services on the date of Medicaid termination at age 19. Refer to Basic Considerations and Procedures for Inpatient Services in this section.

PROCEDURES

Screen for LIM. If the applicant is potentially eligible for LIM, approve RSM pending the disposition of the LIM application.

Follow the steps below to determine RSM eligibility for a child:

Step 1 Contact the applicant if additional information is needed that is not included in the application. A telephone or mail contact is acceptable as no face-to-face interview is required for a RSM Child application. If no additional information is needed, proceed with the application processing.

Step 2 Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

PROCEDURES (cont.)

Step 3 Establish all points of eligibility. Accept the A/R's statement unless information known to the agency conflicts with the A/R's statement or is otherwise questionable.

Step 4 Based on date(s) of birth, apply the appropriate percentage(s) of the FPL to determine eligibility for each child.

Step 5 Accept the A/R's statement of gross income. If the income statement conflicts with information known to the agency, or if otherwise questionable, verify the BG's income from the source of that income.

Step 6 Complete the budgeting process. Refer to Section 2669, RSM Budgeting.

If eligible, approve RSM Child. If any child is ineligible, approve the eligible child(ren) and complete and document the results of a CMD for the ineligible child(ren) prior to denial. If all children are ineligible, complete and document the results of a CMD prior to denial of the AU. If eligibility is denied because of excessive income, provide the A/R with a PeachCare for Kids application and PeachCare for Kids program information.

Step 7 Assistance may continue through the month the child reaches age 19. A review is completed every 6 months to determine continued eligibility. Complete and document the results of a CMD for the ineligible child(ren) prior to termination of RSM.

SPECIAL CONSIDERATIONS

Inpatient Services If a child is receiving inpatient services when the age limit for an income level is reached or when the child turns 19 years of age, eligibility continues if **all** of the following requirements are met:

- reaching age 19 or the age limit for an income level is the sole reason for ineligibility;
- inpatient services are received in a Medicaid participating hospital or nursing facility on the last day of the month in which the age or income limit is reached and the first day of the next month;
- the child remains eligible under all RSM criteria except for age or income limit through the month in which the inpatient stay terminates.

Inpatient Services (cont.)

If the child is transferred directly from one medical facility to another, the extended eligibility can continue if all other requirements are met.

NOTE: Upon discharge or if there is a break in stay in a medical facility, the lower income level must be used if the child is under 19 years of age. If the child has reached 19 years of age, s/he is ineligible upon discharge or if there is a break in stay in a medical facility. Complete and document the results of a CMD prior to termination of RSM.

This coverage can be established in the three months prior to an application, even if the child reaches the age limit in one of the prior months, provided the above criteria are met.

Follow the steps below to extend RSM eligibility beyond the age limit.

Step 1 Verify the inpatient stay that continues beyond the date the child would become RSM ineligible. Continue RSM eligibility through the month following the date of ineligibility and for each month until the child is discharged.

Step 2 Complete and document results of a CMD on the child upon discharge from the medical facility and discontinue RSM.

NOTE: If RSM is terminated before the agency is notified of the inpatient services, verify that the inpatient services were received and reopen the RSM case. Continue RSM until the patient is discharged. Complete and document the results of a CMD prior to terminating RSM when the child is discharged from the medical facility.

2184 – RSM PREGNANT WOMEN

POLICY STATEMENT	RSM Pregnant Women (PgW) provides Medicaid to pregnant women who have Budget Group (BG) income at or below 235% of the FPL and who meet all other eligibility requirements.
BASIC CONSIDERATIONS	For RSM eligibility purposes, pregnancy begins with the month of conception and continues through the 60th day following the termination of pregnancy. Eligibility terminates at the end of the month in which the 60th day falls. Begin the 60-day count on the day of the termination of pregnancy. **NOTE:** Pregnancy termination includes live birth, still birth, spontaneous abortion (miscarriage), therapeutic abortion and elective abortion. RSM is the only COA that considers a woman as pregnant during the 60-day transition period. A pregnant woman who is not eligible as a pregnant woman prior to and/or including the month of pregnancy termination is potentially eligible for RSM during the 60-day pregnancy transition period if she meets eligibility requirements during the 60-day period. A pregnant woman who is correctly determined Medicaid eligible remains financially eligible from the effective month of approval through the end of the 60-day pregnancy transition period, regardless of changes in the BG income. Refer to Section 2720, Continuous Coverage for a Pregnant Woman. **NOTE:** A pregnant woman must continue to meet all non-financial eligibility requirements. **EXCEPTIONS:** • Individuals who receive RSM PgW as Emergency Medical Assistance (EMA) are not required to meet the citizenship or enumeration requirements. Refer to Section 2054, Emergency Medical Assistance. • Individuals who receive RSM PgW are not required to cooperate with CSE and are not required to apply for other benefits. A pregnant woman can be determined eligible for continuous Medicaid coverage based on RSM PgW eligibility in a prior month. The pregnant woman must meet all RSM financial and non-financial requirements, including pregnancy in the prior month and must have incurred a medical expense during the prior month.

BASIC CONSIDERATIONS (cont.)

A pregnant woman is budgeted as two individuals (the pregnant woman and the unborn child). If a multiple-fetus pregnancy is medically verified, increase the BG to include the number of verified fetuses.

NOTE: If a pregnant woman applies for Medicaid for children only, the unborn child cannot be included in the BG.

OTHER CONSIDERATIONS

Presumptive Eligibility

Certain medical facilities are approved by the Division of Medical Assistance (DMA) and provide an on-site Presumptive Eligibility (PE) Medicaid certification to pregnant women who apply for and are presumed financially eligible for RSM.

An abbreviated RSM application is completed by certified Qualified Providers (QP's) at these facilities. The purpose of the PE is to provide Medicaid coverage for pregnant women to receive immediate prenatal care. After certification, the PE application is forwarded to DFCS for a RSM determination, as the PE decision is temporary and does not cover the costs associated with delivery. In some counties, the application is completed by a Right From the Start Medicaid (RSM) Project outreach worker.

Refer to Section 2067, Presumptive Medicaid.

PROCEDURES

Screen for LIM. If the applicant is potentially eligible for LIM, approve RSM pending the disposition of the LIM application. Screen for TANF and assist with the TANF application if the A/R chooses to apply.

Follow the steps below to determine Medicaid eligibility for pregnant woman under RSM:

Step 1 Contact the applicant if additional information is needed that is not included in the application. A telephone or mail contact is acceptable, as no face-to-face interview is required for a RSM PgW or PE application. If no additional information is needed, proceed with the application processing.

Step 2 Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

PROCEDURES (cont.)

Step 3 Obtain verification of pregnancy and number of fetuses from a medical provider, either verbally or in writing. Document verbal verification of pregnancy, noting who verified the information.

NOTE: A pregnancy test performed by the health department, including the test given at the time of the PE application, is acceptable.

Step 4 Obtain the estimated date of delivery (EDD) from a medical provider or from the A/R. Written verification of the EDD is not required.

Step 5 Establish all points of basic eligibility. Accept the A/R's statement unless the statement conflicts with information known to the agency, or is deemed questionable. Document in the case record the conflict of information or reason questioned and the verification that is subsequently requested.

Step 6 Accept the A/R's statement of gross income. If the income statement conflicts with information known to the agency, or if otherwise questionable, verify the BG's income from the source of that income.

Step 7 Complete the budgeting process. Refer to Section 2669, RSM Budgeting.

If eligible, approve RSM PgW. If ineligible, complete and document the results of a CMD.

Step 8 Initiate contact with the PgW recipient in the month prior to the month in which the EDD falls. Continue these monthly contacts to establish that the pregnancy continues.

Step 9 If the pregnancy terminates with a live birth, approve the child for Newborn Medicaid if requirements are met. Refer to Section 2174, Newborn Medicaid.

Continue RSM PgW eligibility 60 days following termination of pregnancy. Terminate eligibility at the end of the month in which the 60th day falls. Begin a CMD for the pregnant woman in the month prior to the last month of RSM PgW eligibility.

2194 – PEACHCARE FOR KIDS

POLICY STATEMENT	PeachCare for Kids (PCK) provides medical insurance for children who are financially ineligible for Medicaid.
BASIC CONSIDERATIONS	PeachCare for Kids (PCK) is available to children from birth through the last day of the month of a child's 19th birthday. Countable income must be less than or equal to 235% of the FPL. Refer to Appendix A2, Financial Limits for Family Medicaid. **EXCEPTIONS:** • If income is below 235% FPL and below the appropriate Medicaid FPL based on the child's age, the child is potentially eligible for Medicaid and ineligible for PCK. • Children who are eligible for Newborn Medicaid are ineligible for PCK. • Pregnant minors who are eligible for RSM PgW are ineligible for PCK. • State and University System employees' children are ineligible for PCK. The applicant's statement of the child's birth date may be acceptable. PCK recipients must meet the Medicaid citizenship/alienage criteria. Referral of the non-custodial parent (NCP) to CSE does not apply. Eligibility for PCK begins the first day of the month in which a complete application, including all applicable premiums, has been received by Dental Health Administrative and Consulting Services (DHACS). PCK does **NOT** provide prior month coverage. If prior month medical bills are owed, approve for Family Medicaid Medically Needy if eligible.
PROCEDURES	Screen under all Medicaid Classes of Assistance (COA). If a child is ineligible for all Medicaid COAs, provide a PCK application and PCK information to the family. **EXCEPTION:** If a child is potentially eligible for ongoing Family Medicaid Medically Needy (FM-MN), refer the child to PCK. If a child is eligible for prior months FM-MN, approve FM-MN for the prior months and refer the child to PCK for ongoing months.

PROCEDURES (cont.)

PCK applications are processed by DHACS, under contract with the Georgia DMA. Applications are mailed or filed on-line. DFCS does not process PCK eligibility.

PCK is included in all CMDs, and should be considered before Family Medicaid Medically Needy for ongoing benefits.

DHACS screens all PCK applications for Medicaid eligibility. An application received for a child who is potentially eligible for Medicaid is returned to the RSM Project for RSM approval.

The applicant's statement of income, unless questionable, is acceptable verification.

OTHER CONSIDERATIONS

A primary care physician must be selected for children eligible for PCK. This may be done at application or after approval. If no primary care physician is selected, a physician will be selected according to the area in which the child lives.

Any physician, medical practice, clinic or hospital that accepts Medicaid also accepts PCK.

PCK covers the same medical services as RSM with the following exceptions:

- Non-Emergency Transportation (NET)
- Targeted Case Management

PCK recipients must pay a $7.50 monthly premium per child. The maximum cost per family is $15.00 per month, regardless of number of children.

EXCEPTION: No premium is charged for children under age six (6).

Applications and brochures or other eligibility information may be obtained on-line at www.peachcare.org, by calling **1-877-GA-PEACH**, from **the RSM Outreach Project 1-800-809-7276** or from any county DFCS office.

2196 – FAMILY MEDICAID MEDICALLY NEEDY

POLICY STATEMENT

Family Medicaid Medically Needy (FM-MN) provides Medicaid coverage for children under 18 years of age and pregnant women whose BG income exceeds limits for all Family Medicaid COAs and PeachCare for Kids.

There are two types of FM-MN cases:

- De facto eligibility is determined when the BG's net countable income is equal to or less than the FM-MN Income Level (MNIL) for the BG size and resources are less than or equal to the FM-MN resource limit.
- Spenddown (SD) eligibility is determined when the BG's net countable income is greater than the MNIL for the BG size and is offset by the incurred medical expenses of the BG. Resources must be less than or equal to the FM-MN resource limit.
-

BASIC CONSIDERATIONS

FM-MN is available to pregnant women who meet any of the following conditions:

- The budget group (BG) income exceeds the RSM PgW income limit.
- The pregnant woman would be eligible for LIM upon the birth of the child except the BG income and/or resources exceed the LIM limits.

FM-MN is available to children under 18 years of age who meet any of the following conditions:

- The child's BG income exceeds RSM and PeachCare income limits.
- The child would be eligible for LIM except for excessive income and/or resources.
- The child is in foster care with income exceeding LIM/CWFC, RSM and PeachCare limits.

Eligibility for all Family Medicaid COAs (including RSM) and PeachCare must be ruled out prior to determining eligibility under FM-MN.

BASIC CONSIDERATIONS (cont.)

RSM income limits vary based on a child's age. Because of this, it is possible that a younger child may be RSM-Child eligible and a sibling may be FM-MN eligible because of RSM ineligibility.

All basic eligibility criteria must be met with the exception of living with a relative within the specified degree of relationship. Refer to Chapter 2200, Basic Eligibility Criteria.

Resource Limit

FM-MN resource limits are based on SSI resource limits.

If resources are less than or equal to the applicable resource limit at any time during a month, the BG is resource eligible for the entire month.

Use the chart below to determine the resource limit for a BG.

EFFECTIVE	NUMBER IN BUDGET GROUP							
	1	2	3	4	5	6	7	8
7/1/98 through the present	$2000	4000	4100	4200	4300	4400	4500	4600
Add $100.00 for each BG member above eight.								

Review Period

The FM-MN review period is 6 months. Each month of the 6 month FM-MN review period is a separate budget period and eligibility is determined for each month individually. The first budget period begins on the first day of the month in which the application is filed and ends with the last day of the application month. The second through sixth budget periods begin on the first day and end on the last day of each of the months 2 through 6. The review period begins on the first day of the month in which the application is filed and continues through the last day of the sixth consecutive month.

Prior Months

FM-MN is available for the three months prior to the application month. Each of the three prior months is budgeted separately using actual income and expenses for each of those months.

Income and expenses are anticipated for each one-month budget period in the six-month review period.

BASIC CONSIDERATIONS (cont.)

De Facto FM-MN

If the BG's net countable income for the budget period is equal to or less than the MNIL for the BG size for the budget period, the AU is de facto eligible for Medicaid.

De facto FM-MN eligibility begins on the first day of the month and expires on the last day of the month of the budget period, provided no changes occur during the month that affects eligibility.

Spenddown FM-MN

If the BG's net countable income for the budget period exceeds the MNIL for the BG size, the excess amount is the SD.

The SD must be met before the AU is approved for FM-MN.

The SD is met by subtracting allowable medical expenses of the BG members from the SD until the SD is zero.

When the SD is met, the case is considered FM-MN SD eligible and the AU members are approved for Medicaid effective the day the SD is met. Eligibility continues through the end of the month.

Individuals Whose Medical Expenses Can Be Used

The following individuals' medical expenses can be used to meet the SD:

- any BG member
- a deceased spouse or child of a BG member if s/he could have been included in the BG at the time the medical expense was incurred

  NOTE: Enumeration is not required for a deceased individual.

- the child of a BG member who has reached 18 years of age if that child could have been included in the BG at the time the medical expense was incurred.

  NOTE: The child does not have to be currently living in the home with the BG and does not have to be enumerated.

- the parent of a minor parent.

BASIC CONSIDERATIONS (cont.)

Medical expenses are used to meet the SD if they meet all of the following conditions.

- the bill is unpaid

  EXCEPTION: Medical bills paid during the budget period are allowed.

- a BG member is legally obligated to pay the expense

- there is no TPL coverage to pay the expense. Refer to Special Considerations and Chart 2196.1, Allowable Medical Expenses in FM-MN in this section.

The SD may be met using medical expenses incurred prior to the budget period. If this situation occurs, the AU is eligible from the first day of the one-month budget period. Any remaining portion of the unpaid expense not used to meet SD in a month may be used to meet SD in subsequent months, provided the bill remains unpaid during those months.

If the SD is not met by previously incurred bills, the case is held in suspense status until bills are incurred that meet the SD for any month in the review period.

If the SD is met during a budget period, a first day liability (FDL) is calculated for the day the SD is met. The BG is responsible for paying the FDL. Form 400, MN First Day Liability is used to inform the A/R, the provider and DMA of the FDL amount for which the A/R is responsible.

BASIC CONSIDERATIONS (cont.)

If an A/R submits a medical expense after the expiration of the budget period, the bill can be used to meet or adjust the SD for the expired budget period only if it is submitted within three months of the expired period, unless Good Cause exists.

NOTE: If the bill is submitted in the fourth month after the expired FM-MN budget period and Good Cause does not exist, the bill can be used to meet a current or future SD if a BG member continues to be legally obligated to pay it and there is no TPR for that bill.

If an AU member becomes eligible for another Medicaid COA while the FM-MN case is in suspense status, terminate the review period and approve the AU member for the other COA.

A woman whose medical bills meet SD the day **after** the day the pregnancy terminates is **not** eligible for Medicaid as a pregnant woman.

NOTE: The newborn does not qualify for NB Medicaid.

A pregnant woman who applies for FM-MN prior to the termination of the pregnancy and whose medical bills meet SD on or before the day of the termination of pregnancy can be eligible for Medicaid through the month in which the 60th day from pregnancy termination occurs.

Begin Authorization Date

FM-MN Medicaid begins on the Begin Authorization Date (BAD), a specific day during the budget period.

NOTE: Medical expenses incurred prior to the BAD in a budget period are not paid by DMA.

The BAD is any of the following dates:

- the first day of the budget period if de facto eligibility is established
- the first day of the budget period if SD is met using only unpaid medical bills incurred prior to the budget period
- the day in the budget period in which the SD is met using bills incurred during the budget period or a combination of bills incurred during and prior to the budget period. This day can also be the first day of the budget period.

PROCEDURES

Screen for eligibility for all classes of Family Medicaid and for PeachCare for Kids.

If the AU is ineligible for all Family Medicaid COAs and PeachCare for Kids based on income or resources, proceed with FM-MN.

Follow the steps below to establish FM-MN eligibility.

Step 1 Conduct a face-to-face interview with the A/R.

Step 2 Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

Step 3 Establish each budget month of the review period.

Step 4 Determine the countable resources of the BG for the budget period and compare to the FM-MN resource limit for the BG size to determine resource eligibility.

Step 5 Determine if a TPL resource exists that will pay for all or any portion of the medical expenses.

Step 6 Complete a FM-MN budget using the anticipated income and expenses of the BG. Refer to Section 2671, Family Medicaid Medically Needy Budgeting.

Step 7 If the BG net countable income is at or below the MNIL for the BG size, the AU is de facto eligible. Complete the following:

- Approve the members for FM-MN Medicaid effective the first day of the budget period.
- Notify the AU and DMA of the BAD and the ending date of eligibility, the Medicaid number(s) for all AU members and issue Medicaid Certification for each month of de facto eligibility, including retroactive months.

If the AU is **not** de facto eligible, proceed to Step 8.

PROCEDURES (cont.)

Step 8 If the net countable income of the BG exceeds the MNIL for the BG size, the amount of the excess is the SD. Explain to the A/R the SD process.

Step 9 Determine whose expenses are allowed as deductions from the SD.

Step 10 Obtain itemized copies of bills for unpaid medical expenses and those paid during the budget period for the individuals determined in Step 9.

If a TPR exists, determine how much the TPR has paid or will pay toward these bills and subtract the TPR payment(s) from the bill(s). Use only the remaining amount toward meeting the SD.

Refer to Special Considerations and to Chart 2196.1, Allowable Medical Expenses for FM-MN in this section.

Step 11 Sort medical bills in ascending (oldest to most recent) chronological order.

Deduct from the SD the allowable prior medical bills (bills that were incurred prior to the budget period).

If the SD is met using prior medical expenses, approve FM-MN Medicaid for the AU members on the first day of the budget period. Complete the following actions:

- Approve FM-MN Medicaid for the AU members beginning the first day of the budget period.
- Notify the AU. Notification includes the BAD, the ending date of eligibility and the Medicaid numbers for each AU member.
- Provide to the AU a Certification of Medicaid Eligibility for any/all approved months.

If the SD is **not** met using prior medical expenses, proceed to Step 12.

PROCEDURES (cont.)

Step 12 Deduct allowable medical expenses incurred during the budget period in ascending (oldest to most recent) chronological order.

Rank bills incurred the same day as follows:

1. incurred by BG members not included in the AU;

2. incurred by AU members but not covered by Medicaid (non-covered expenses such as over-the-counter medications or bills payable to non-Medicaid providers);

3. incurred by AU members payable to a Medicaid provider, the lowest dollar amounts first.

If the SD is met, proceed to Step 13.

If the SD is **not** met, skip to Step 14.

Step 13 If the SD is met by bills ranking order 1 or 2 (as described in Step 12), **Form 400, First Day Liability** is not required, as the AU has no First Day Liability (FDL).

Complete the following actions:

- Approve the AU members for Medicaid to begin on the day in which the bill that brought the SD to zero (the **break-even** bill) was incurred.

- Notify the AU. Notification includes the BAD and the ending date of eligibility and the Medicaid numbers for each AU member.

- Provide to the AU a Certification of Medicaid Eligibility for any/all approved months.

PROCEDURES (cont.)

Step 13 (cont.) If the SD is met by bills in ranking order 3 (ad described in Step 12), **Form 400, First Day Liability** is necessary.

Complete the following actions:

- Issue a Form 400 for the break-even bill showing the dollar amount of the FDL as the client liability.

- Issue Form 400 with a client liability of zero for all other bills incurred on the BAD that were not used to meet the SD.

  NOTE: Do not issue Form 400 for bills incurred on the BAD that were applied to the SD prior to the break-even bill as no portion of these bills is payable or reimbursable by DMA and are the total responsibility of the client.

- Report to the client and DMA the amount of the break-even bill used to meet the SD as the FDL. If a manual Certification of Eligibility is used annotate the Certification, **FORM 400 REQUIRED.** The Certification must also include the month, day and year of the BAD and the ending date of eligibility.

  NOTE: For group medical practices, clinics, or other provider names that do not include the name of a specific physician or clinician who performed the medical service, include the name of the individual in addition to the group name.

- Notify the AU. Notification includes the BAD, FDL, the ending date of eligibility and the Medicaid numbers for each AU member.

- Provide to the AU a Certification of Medicaid Eligibility for any/all approved months.

Step 14 If the SD is not met, place the case in suspense status until medical expenses adequate to meet the SD are incurred.

Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred.

PROCEDURES (cont.)

Step 15 When medical expenses equal the SD for cases in suspense status, complete the following actions:

- Determine actual income already received during the budget period.
- Recalculate the SD using the actual income and any income anticipated to be received in the remainder of the budget period.

Step 16 If the recalculated SD is met, approve the AU for FM-MN, completing actions outlined in Step 13.

Step 17 If the recalculated SD (see Step 15) is not met, place the case in suspense status and notify the AU of the amount of the SD for each budget period month remaining in the review period.

Step 18 Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred.

Step 19 If the SD is met, approve FM-MN according to procedures outlined in Step 13.

If the SD is not met during the one-month budget period, continue the case in suspense until enough bills are incurred to meet the SD in another budget period. Review the case every six months for continued eligibility.

SPECIAL CONSIDERATIONS

The following types of medical expenses of a BG member who has the legal obligation to pay the expenses can be used to meet the FM-MN SD.

Medical Expenses

- Services provided by the following:
  - hospital
  - registered nurse
  - medical clinic
  - licensed practical nurse
  - physician
  - dentist
  - hospice

Medical Expenses (cont.)

- chiropractor
- psychiatrist
- osteopath
- mental health clinic
- oculist
- personal attendant (sitter)
- nursing assistant
- optician
- optometrist

- Medical care purchases, such as the following:
  - medical tests
  - eye glasses
  - hearing aids
  - contact lens
  - prescription drugs
  - medical supplies (bandages, tape, syringes, etc.)
  - dentures
  - over-the-counter drugs
  - prosthetic devices
  - immunizations
  - transportation costs to medical services (allow $.21 per mile or actual cost, whichever is less).

- Elective surgery
- Health insurance premiums
- Medically necessary ambulance service

NOTE: These lists are not all inclusive.

Explore TPR coverage before applying any medical expenses as deductions from the SD.

Verification of Medical Expenses

Verify incurred medical expenses by any one of the following:

- itemized medical bill or statement
- receipts for payment of medical expenses
- medical Explanation of Benefits (EOB) listing covered/ non- covered and paid/unpaid medical expenses
- health insurance statement listing amount paid
- odometer reading for mileage expense
- other sources deemed appropriate.

Use the following chart to determine which medical expenses can be deducted to meet the spenddown in a MN case:

CHART 2196.1 – ALLOWABLE MEDICAL EXPENSES FOR FM-MN

ALLOWABLE	NOT ALLOWABLE
• Medical bills belonging to individuals who are or could have been included in the BG when the expenses were incurred. • Unpaid bills that a BG member remains liable for paying. • Unpaid bills incurred **prior** to the budget period and not used in a prior month(s) determination of eligibility nor used to meet a prior spenddown. • Bills that a BG member incurred during the budget period, whether paid or unpaid. • Bills applied to an earlier spenddown that was never met can be deducted in a current spenddown if the bills are still owed and the individual who incurred them is still a BG member. • Medical bills used in Aged, Blind, Disabled MN budgets in the spenddown process. • Bills not presented to the worker during the budget period provided the BG member remains liable for payment as of the first day of the new budget period. • For prior months MN budget period only: past medical debts, which have been written off subsequent to the budget period. **NOTE:** If the bill was forgiven or written off prior to the end of the budget period, it is not allowed. • the remainder of unpaid bills incurred prior to the budget period that has been turned over to a collection agency. If these medical bills are consolidated with other bills, only the portion that can be verified as unpaid medical expenses can be deducted. **NOTE:** Monthly payments to a collection agency cannot be deducted. • Medical expenses related to pregnancy: - allow when BG becomes obligated for payment of the expense - include prepayment of delivery fees or admission fees by the hospital. - Bills from any time period can be used as long as a BG member still has a legal obligation to pay the bill. The incurred bills are not limited to the time of the emergency service.	• Medical bills past or present, which will be paid by a liable third party. **EXCEPTIONS:** Deductibles and co-pays to be paid by the BG are allowed. If a decision is pending as to who is liable, allow the deduction with the understanding that the eligibility is revoked if the decision is reversed. If a bill is paid in full or in part to a provider or as a reimbursement to a BG member by a public program funded by the state or programs of political subdivisions of the state, allow this as a deduction as long as **no federal funds** are used and the bill was paid during the budget period. Verify the source of the funding to ensure there are no federal funds used. **NOTE:** Allow a reimbursement for this third party only **if** the bill was paid by the BG member and reimbursed in the same budget period. Do not allow the bill as a deduction if the BG member paid the incurred expenses prior to the budget period and was reimbursed in the budget period. • For ongoing MN budget periods, past medical debts which were forgiven or written off by the provider prior to the first day of a budget period or prior to the date the case is brought to final disposition. • Medical expenses paid by Medicaid under three months-prior coverage. • Medical bills applied in another budget period in which spenddown is met.

Use the following chart to determine procedures for the use of Form 400, 964 and 246 in MN.

CHART 2196.2 – MN INSTRUCTIONS ON FORMS 400, 964 AND 246			
IF	**THEN ISSUE CERTIFICATION OF ELIGIBILITY**	**THEN ISSUE DMA FORM 400**	**THEN ISSUE CLIENT NOTIFICATION**
De facto eligible, i.e., there is no spenddown at the time of application	To A/R for providers. Do not reference DMA Form 400.	Not required.	No first day liability is put on the form.
There was spenddown at the time of application but it was met with bills incurred prior to the budget period.	To A/R for providers. Do not reference DMA 400.	Not required.	No first day liability is put on the form.
Spenddown is met by a BG member who is potentially Medicaid eligible and the bill is issued by a Medicaid provider for a Medicaid-covered expense. Also, spenddown is met with bills incurred during the budget period.	To A/R for providers. Note in remark section **DMA F400 required.** Retain a copy for the case record.	To provider, whose bill meets spenddown (i.e., the break-even claim). Show the actual dollar amount to be paid by the recipient for that bill. To every Medicaid provider with a subsequent bill on the BAD, show the amount to be paid by the recipient as zero. In both of the above situations, keep a copy of each DMA 400 in the case record.	Enter the first day liability amount (column 5, Form 238 on the line immediately preceding the first line of the BAD).
Spenddown is met with bills incurred by a BG member who is not Medicaid eligible or with a bill from a non-Medicaid provider or with an expense that is not covered by Medicaid.	To A/R for providers. **NOTE: DMA Form 400 not required.**	Not required.	No first day liability is put on the form.

2198 – BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT

POLICY STATEMENT

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 under Title XV of the Public Health Services Act provides Medicaid coverage to women who are in need of treatment for breast or cervical canter.

BASIC CONSIDERATIONS

Effective July 1, 2001 the Department of Community Health (DCH) began implementation of the Breast and Cervical Cancer Prevention (BCCP) and Treatment class of assistance (COA) for women who are in need of treatment for breast and cervical cancer, including pre-cancerous conditions and early stage cancer.

Public Health or one of its partner affiliates completes the breast and/or cervical cancer screening in accordance with the Center for Disease Control (CDC) guidelines established under Title XV.

To be eligible under the BCCP COA an A/R must meet the following conditions:

- Screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program and found to be in need of treatment for either.
- Have no creditable health coverage, including health insurance, Medicare and/or Medicaid.

  EXCEPTION: There may be limited circumstances where the A/R has creditable coverage but is in a period of exclusion such as a pre-existing condition or where life time limits have been exhausted. In these situations, the A/R is considered uninsured.
- Is under age 65.
- Is a U.S. citizen or a lawfully admitted alien.

  NOTE: A/R's who do not meet the citizenship requirement may qualify for this COA using EMA criteria.

BASIC CONSIDERATIONS (cont.)

Other Eligibility Factors

There is **no** asset or income test under the BCCP COA. The A/R's income and assets are totally disregarded.

The A/R must be a Georgia resident.

A/R's approved for this COA are entitled to the full range of Medicaid covered services. Eligibility for coverage ends when the A/R's course of treatment is completed or they are no longer meet eligibility requirements (for example, they have attained the age of 65 or obtained creditable health coverage) or they become eligible under another Medicaid COA.

Eligibility begins the month of application if the A/R meets all eligibility criteria. Retroactive Medicaid is available provided the A/R was screened and diagnosed for breast or cervical cancer and meets all other eligibility criteria in the prior month(s) requested.

PROCEDURES

Process/Implementation

This program involves the Department of Community Health, Division of Public Health and the Right from the Start Medicaid Project. The eligibility determination is a two-pronged process consisting of a presumptive eligibility determination and a determination of eligibility for regular categories of Medicaid.

Presumptive Eligibility Process

Women who have received a diagnosis or suspect they have cervical or breast cancer should be referred to their local public health department. Public health or one of its partner affiliates \will complete the breast and/or cervical cancer screening procedures in accordance with CDC guidelines established under Title XV.

If the result of the screening is an affirmative diagnosis of breast or cervical cancer, the woman will be contacted by the health department and advised of the results. She will be given an explanation of the Breast and Cervical Cancer Prevention and Treatment program and encouraged to return to the health department to apply. When the woman returns, public health will complete a Presumptive Eligibility determination. This consists of completing an application, interviewing the woman and determining eligibility in accordance with the basic eligibility criteria.

PROCEDURES (cont.)

Presumptive Eligibility Process (cont.)

As part of the Presumptive Eligibility determination process, health department personnel are required to complete the application, Eligibility Determination for Women's Health Medicaid Program; citizenship affidavit; Form 285, Health Insurance Questionnaire; and the Notice of Action.

Public Health personnel will obtain Medicaid identification numbers by contacting state RSM Project staff. The Medicaid identification number will be entered on the application. Until this COA is added to the SUCCESS system, Medicaid numbers will consist of thirteen digits, begin with the series 175 and end in D00.

If the A/R is determined eligible, they will be given two copies of the application, representing the client and pharmacy copies. The A/R will have immediate access to health care and the full range of Medicaid covered services. The A/R is also given a Notice of Action form advising of approval and a list of cancer specialists in their area.

Public Health will fax the eligibility determination to state RSM Project staff for entry into the Medicaid Management Information System (MMIS) if the application is approved and the A/R will receive the goldenrod Medicaid card as long as they remain eligible. A/R's eligible under this COA will not be assigned to Georgia Better Health Care

If the A/R is determined to be ineligible for the program, public health gives a Notice of Action advising of ineligibility, an application for the State Cancer Aid Program and a list of cancer specialists in their area.

NOTE: Women who are screened in accordance with CDC guidelines by providers other than the health departments or their partner affiliates are eligible to participate in this program. They should be referred to their local health department to complete an application for the Breast and Cervical Cancer Prevention and Treatment Program.

PROCEDURES (cont.)

Eligibility Determination

Public Health will forward to local RSM Project staff copies of all applications, approved or denied, for review and to determine the A/R's ongoing eligibility under the BCCP COA or any other potential Medicaid COA such as RSM, Low Income Medicaid and Work Transition Medicaid.

If continued eligibility is determined for BCCP or RSM COA, state RSM Project staff have the responsibility for ongoing case maintenance. If the A/R is potentially eligible for another COA, the local RSM Project staff will refer the application to the Department of Community Health (DCH) for eligibility to be determined. DCH is responsible for entering the eligibility information into MMIS and ongoing case maintenance. Reviews will be completed annually and reminder notices will be sent out after the sixth month of eligibility instructing A/R's to report changes.

When an A/R is found to be ineligible by local RSM Project staff, the A/R is sent appropriate notification and another application for the State Cancer Aid program. Appeal rights are applicable when eligibility for continued Medicaid is denied. Appeals and all inquiries pertaining to Breast and Cervical Cancer Prevention and Treatment Medicaid cases should be directed to the RSM Project at 1-800-809-7276.

MEDICAID MANUAL TABLE OF CONTENTS		
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2201 - BASIC ELIGIBILITY CRITERIA OVERVIEW

POLICY STATEMENT

Basic Eligibility Criteria are non-financial requirements the Assistance Unit (AU) members must meet in order to qualify for Medicaid.

BASIC CONSIDERATIONS

ABD Medicaid

The following Basic Eligibility Criteria are required when determining eligibility under any ABD Medicaid Class of Assistance (COA).

- Aged, Blind or Disabled
- Application for Other Benefits
- Citizenship/Alienage
- Enumeration
- Residency
- Third Party Resource assignment

EXCEPTIONS:

- Application for Other Benefits is **NOT** a requirement for QMB, SLMB, QI-1 AND QI-2 COAs.
- Citizenship/Alienage and Enumeration are **NOT** requirements for Emergency Medical Assistance (EMA).
- Third Party assignment is **NOT** a requirement for SLMB, QI-1 and QI-2 COAs.

The following Basic Eligibility Criteria are requirements when determining eligibility under any Medicaid CAP COA:

- Length of Stay
- Level of Care

EXCEPTION: Length of Stay is **NOT** required for Deeming Waiver.

Refer to Section 2101, ABD COA Overview.

BASIC CONSIDERATIONS (cont.)

Family Medicaid

The following Basic Eligibility Criteria are requirements when determining eligibility under a Family Medicaid COA. Refer to the specific COA to determine if the criterion applies.

- Age
- Application for Other Benefits
- Citizenship/Alienage
- Cooperation with CSE
- Enumeration
- Residency
- Third Party Resources
- Living with a Specified Relative

EXCEPTION: Citizenship/Alienage and Enumeration are **NOT** requirements for Emergency Medical Assistance (EMA).

PROCEDURES

Establish and verify, if required, that the A/R meets all Basic Eligibility Criteria required for the COA under which Medicaid eligibility is being determined or continued.

If all Basic Eligibility Criteria requirements are met, proceed with the financial eligibility determination.

Failure to Comply with Basic Eligibility Criteria

If a member of the AU fails to comply with one or more of the required Basic Eligibility Criteria, deny or terminate Medicaid or apply a penalty, depending on the COA under which Medicaid is being determined.

If the Basic Eligibility Criterion the AU member has failed to meet is not required under another COA, complete a CMD to determine eligibility under the other COA before denying or terminating Medicaid.

Failure to Comply-ABD Medicaid

If the A/R fails to meet one or more of the Basic Eligibility Criteria, deny or terminate ABD Medicaid.

Failure to Comply-Family Medicaid

Do not include an adult in the AU if s/he fails to comply with Basic Eligibility Requirements. A non-compliant adult **is** included in the BG if s/he is a parent or spouse of an AU member.

EXCEPTION: If an adult fails to apply for potential benefits, exclude the parent and everyone for whom s/he is financially responsible, unless the adult is included in a RSM PgW AU.

PROCEDURES

Failure to Comply-Family Medicaid (cont.)

Remove from the Family Medicaid AU, but not the BG the adult who fails to comply with any of the following requirements:

- cooperation with his/her own Enumeration
- identification and provision of information regarding any TPR available to the AU
- referral to and cooperation with CSE

EXCEPTIONS:

- Pregnant women in any COA are not referred to and are not required to cooperate with CSE for an unborn child.
- RSM-eligible pregnant women are not referred to, and are not required to cooperate with CSE for an existing child
- A referral to CSE is not required for a Medicaid-eligible individual age 18 years or older.
- A referral to CSE is **NOT** made for child-only Medicaid cases.
- A child-only Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid under the same case as the child or under any related case. An AU which contains a penalized adult is **NOT** considered a child-only case.

Refer to specific Basic Eligibility Requirements in this Chapter.

Remove the child from the AU and BG if the responsible adult in the AU or BG fails to enumerate the child and/or fails to apply for benefits to which the child may be entitled.

EXCEPTION: These requirements do not apply to NB Medicaid or individuals receiving Four Months Extended Medicaid because of Child Support COA (4MCS), or Medicaid applications for deceased individuals. For EMA only, enumeration does not apply.

VERIFICATION

ABD Medicaid

Basic Eligibility Criteria must be established when determining eligibility under all ABD COAs.

EXCEPTIONS: It is not necessary to verify Enumeration, Residency or U.S. Citizenship, unless questionable.

Family Medicaid

The statement of the A/R may be accepted as verification for all Basic Eligibility Criteria unless there is information known to the agency that conflicts with the statement of the A/R or if the statement is otherwise questionable.

EXCEPTIONS:

- Pregnancy must be verified for any woman applying for Medicaid coverage as a pregnant woman.
- Alienage must be verified for non-citizens.
- Any information that conflicts with information known to the agency, or that is otherwise questionable must be verified.

The following charts list Basic Eligibility Criteria and the COAs to which each applies.

CHART 2201.1 ABD MEDICAID BASIC ELIGIBILITY CRITERIA

ABD MEDICAID CLASS OF ASSISTANCE	AGEC/BLIND/DISBLED	APPLICATION FOR OTHER BENEFITS	CITIZENSHIP/ ALIENAGE	ENUMERATION	LENGTH OF STAY	LEVEL OF CARE	RESIDENCY	THIRD PARTY RESOURCES
SSI Medicaid (SSI)	X	X	X	X			X	X
Pickle (PL 94-566)	X	X	X	X			X	X
Disabled Adult Child (PL 99-643)	X	X	X	X			X	X
Former SSI-Disabled Child	X	X	X	X			X	X
Disabled Widow(er)	X	X	X	X			X	X
Widow(er) Age 60-64 (PL 100-203)	X	X	X	X			X	X
1984 Widow(er) (PL 99-272)	X	X	X	X			X	X
1972 COLA (PL 92-603)	X	X	X	X			X	X
Community Care Services Program	X	X	X	X	X	X	X	X
MRWP/CHSS	X	X	X	X	X	X	X	X
Deeming Waiver	X	X	X	X		X	X	X
Hospice (at home or institutionalized)	X	X	X	X	X	X	X	X
30 Day Hospital	X	X	X	X	X	X	X	X
Laurens County Head Injury Waiver	X	X	X	X			X	X
Independent Care Waiver Program	X	X	X	X	X	X	X	X
Model Waiver Services	X	X	X	X			X	X
Nursing Home	X	X	X	X	X	X	X	X
QMB	X		X	X			X	X
SLMB	X		X	X			X	
QI-1	X		X	X			X	
QI-2	X		X	X			X	
QDWI	X	X	X	X			X	X
ABD Medically Needy (AMN)	X	X	X	X			X	X
ABD AMN for Nursing Home/Hospice	X	X	X	X		X	X	X

CHART 2201.2 FAMILY MEDICAID BASIC ELIGIBILITY CRITERIA

FAMILY MEDICAID CLASS OF ASSISTANCE	AGE	APPLICATION FOR OTHER BENEFITS	CITIZENSHIP/ ALIENAGE	COOPERATION WITH CHILD SUPPORT ENFORCEMENT *	ENUMERATION	LIVING WITH A SPECIFIED RELATIVE	RESIDENCY	THIRD PARTY RESOURCES
Low Income Medicaid (LIM)	X	X	X	X	X	X	X	X
Transitional Medical Assistance (TMA)	X		X	X	X	X	X	X
Four Months Child Support (4MCS)	X	X	X	X	X	X	X	X
LIM in Nursing Home	X	X	X	X	X		X	X
Newborn	X		X			X	X	X
RSM Child	X	X	X	*	X		X	X
RSM Pregnant Woman (RSM PgW)			X		X		X	X
State Adoption Assistance (SAA) Medicaid	X	X	X	X	X		X	X
Child Welfare Foster Care (CWFC) Medicaid	X	X	X	X	X		X	X
PeachCare for Kids	X		X		X		X	X
Family Medicaid Medically Needy	X	X	X	X	X		X	X

* no referral to Child Support Enforcement is made for child-only Medicaid cases. Refer to Section 2250, Child Support Enforcement for definition of a child-only Medicaid AU.

2205 – AGED, BLIND, DISABLED REQUIREMENT FOR ABD MEDICAID

POLICY STATMENT	To be eligible for ABD Medicaid, the applicant/recipient (A/R) must be determined to be aged, blind or disabled.
BASIC CONSIDERATIONS	Verify that the A/R is aged if the A/R alleges to be 65 or older. Verify blindness or disability in all other situations.
PROCEDURES **Aged**	Verify that the A/R is aged by use of one of the following: • birth certificate • baptismal record • SSA record that shows date of birth, e.g. - BENDEX/SDX - Medicare card issued prior to 1/74 - Any written verification from SSA • any State issued ID card or Driver's License **OR** Two documents over 5 year old which record the same month and year **OR** Three reliable documents indicating the same year of birth. NOTE: Consider the age requirement met if the A/R is 65 on the first day of the month. NOTE: If the A/R turns 65 during a month, approve as aged for that month, but process the case on or after the A/R's 65th birthday. If the A/R is not aged, verify whether the A/R is blind or disabled.
Blindness or Disability	Verify blindness or disability using one of the following sources: • Prima facie evidence • Disability Adjudication Section (DAS) • State Medicaid Eligibility Unit (SMEU) NOTE: Form DMA-6 is not verification of disability.
Prima Facie Verification	Prima facie evidence includes receipt of the following benefits: • RSDI disability benefits • Railroad Retirement disability benefits • Medicare • For SSI approvals only, the SDX disability/blind date verifies when disability began.

PROCEDURES (cont.)

Prima Facie Evidence (cont.)

If no prima facie evidence exists, verify disability or blindness by means of a disability decision from DAS or SMEU.

EXCEPTION: Receipt of Medicare as a result of a kidney transplant, renal failure or dialysis is **not** prima facie evidence of disability. The Medicare number will have a **T** as the Beneficiary Identification Code (BIC).

When to Request DAS Verification

Request the results of a disability determination from DAS when no prima facie evidence exists for any of the applicable months prior to an approved SSI application.

NOTE: DAS usually determines the disability onset date, including months prior to an approved SSI application. If available, check SDX on approved SSI recipients to verify the disability onset date. If the onset date given covers the prior months disability is requested for, this onset date is prima facie evidence of disability and **no** SMEU decision is required. If current SDX information is not available, send a Form 71 to DAS for any months prior to an approved SSI application and only use SMEU procedures in situations where DAS indicates that they did not establish disability for those months. DAS does not complete disability determinations for months prior to denied applications. Use SMEU procedures for these situations.

How to Request DAS Verification

Send Form 71 to DAS.

Review the decision when Form 71 is returned by DAS.

Use the following chart to determine how to use a DAS decision to verify blindness/disability.

CHART 2205.1 – VERIFYING BLINDNESS OR DISABILITY WITH A DAS DECISION

IF DAS	THEN
determines the A/R is disabled or blind in any of the months requested	the disability requirement is met for these months. Proceed to other eligibility criteria.
determines the A/R is not blind or disabled in any of the months requested	deny the application for these months.
indicates a determination has not been made for any of the months requested	obtain a SMEU decision for these months.

PROCEDURES (cont.)

When to Request SMEU Verification

Request a decision from SMEU when there is no prima facie evidence of blindness or disability, there is no pending SSI application or a determination was not rendered by DAS for the prior months.

How to Request SMEU Verification

Follow the steps below to request a SMEU disability decision to verify blindness or disability.

Step 1 The EW completes Form 188 Social Data Report in detail.

Step 2 Obtain any of the following medical information applicable to the A/R:

- Form DMA-6, if available
- Form 115, Report of Eye examination
- Hospital records, including discharge summary if available
- Physician's medical records
- Psychiatric and/or psychological examination reports
- Current therapy notes (speech, occupational or physical)
- X-ray and laboratory reports
- Death Certificate

NOTE: The above list is not all-inclusive. If medical information is not available and/or is incomplete, have Form 181-1, State Medical Information, completed by an examining physician. Complete Form 375, Authorization for Payment/Request for Record, if the county DFCS authorizes payment of the fee for the medical exam.

Step 3 Attach all medical information and Social Data to Form 245, SMEU Cover Letter, and submit to the following address:

State Medicaid Eligibility Unit
Division of Family and Children Services
Two Peachtree Street, NW, Suite 21.467
Atlanta, GA 30303

Step 4 Review the report on SMEU Decision of Approval/Denial when received back in the county office.

PROCEDURES
(cont.)

Use the following chart to determine how to use a SMEU decision to verify disability or blindness:

CHART 2205.2 – VERIFYING BLINDNESS OR DISABILITY WITH A SMEU DECISION	
IF SMEU determines the A/R is	THEN
disabled or blind for any of the months requested	the ABD requirement is met for these months. Proceed to other eligibility criteria.
not disabled or blind for any of the months requested	the ABD requirement is **not** met for these months. Deny the application for these months.

Use the following chart to determine when to begin verification of blindness or disability with the DAS procedures and when to begin with the SMEU procedures:

CHART 2205.3 – WHEN TO USE DAS VS. SMEU PROCEDURES	
IF the AR	**THEN**
has an approved SSI application **AND** applies for Medicaid for any of the months immediately prior to the month of the SSI application	follow the DAS procedures, if onset date is not available from current SDX information.
has a pending SSI application **AND** applies for Medicaid for any of the months immediately prior to the SSI application	deny the application pending the decision from SSA using the appropriate system code to indicate SSI pending and refer the A/R to SSA, if appropriate.
is potentially eligible for SSI and RSDI and has not applied **AND** requests Medicaid for any of the months immediately prior to the current month	deny the application pending the decision from SSA using the appropriate system code to indicate financially eligible for SSI and refer the applicant to SSA to apply for SSI and RSDI.
is financially ineligible for SSI for all of the months for which Medicaid is requested **AND** has a RSDI application pending (five month waiting period only)	follow the SMEU procedures.

PROCEDURES
(cont.)

CHART 2205.3 – WHEN TO USE DAS VS. SMEU PROCEDURES	
If the A/R	**THEN**
is deceased **AND** has never filed an application for SSI **AND** the surviving spouse or another individual requests Medicaid to cover unpaid medical bills	follow the SMEU procedures.
has a pending SSI application **AND** dies prior to SSA's approval of the SSI **AND** the surviving spouse requests Medicaid to cover any unpaid medical bills	follow the DAS procedures. NOTE: DAS is responsible for completing disability determinations for SSI applicants who die prior to the completion of the SSI application only when they have a surviving spouse.
has a pending SSI application **AND** dies prior to SSA's approval of the SSI with no surviving spouse **AND** the A/R's personal representative requests Medicaid to cover unpaid medical bills	follow SMEU procedures.
has a denied SSI application **AND** requests Medicaid for any of the 3 months prior to the SSI application	follow SMEU procedures.
SSI application is denied due to failure to meet the disability criteria **AND** the A/R requests Medicaid ongoing through DFCS	deny the application and refer the applicant to SSA to reapply for SSI or request a reconsideration of the SSI decision.

Verification File the disability verification obtained through prima facie evidence or from DAS or SMEU in the case record.

Documentation Document the method of verification.

SPECIAL CONSIDERATIONS

When SSA makes a determination of **not** disabled for either RSDI or SSI, this ruling is in effect for 12 months. However, if the A/R alleges a worsening of his/her condition or if a different disabling condition has occurred, DFCS may conduct a review of the disability **if** the A/R is now financially ineligible for SSI and has applied for benefits through DFCS.

- Follow SMEU procedures to verify disability.
  It is important to submit medical evidence that substantiates the worsening and/or different condition alleged.
- Document the applicant's allegation of the change in his/her condition on the Form 188, Social Sata Report, completed as part of the SMEU procedures.
- Refer to SSA to apply for RSDI, but do not wait for SSA's disability determination prior to processing the case. If SSA ultimately determines the A/R is not disabled, deny/close the Medicaid case regardless of a favorable SMEU decision. Send timely notice and recommend that the A/R appeal the SSA determination.

If an A/R's SSI has been terminated for a financial or non-financial reason other than failure to meet the disability requirement and s/he has applied for Medicaid through DFCS, the prior receipt of SSI is prima facie evidence of disability for twelve months following the last month of receipt of SSI.

2210 - APPLICATION FOR OTHER BENEFITS

POLICY STATEMENT

An Applicant/Recipient (A/R) for Medicaid must apply for and accept all other monetary benefits, payments or allotments to which s/he or any member of the Assistance Unit (AU) or Budget Group (BG) may be entitled in order to be eligible for Medicaid.

BASIC CONSIDERATIONS

Application for other benefits must be made prior to the approval of the Medicaid application.

EXCEPTIONS:

- Application for other benefits is not required for the following COAs:
  - Newborn Medicaid
  - TMA
  - RSM PgW
  - QMB
  - SLMB
  - QI-1
  - QI-2
- A pregnant woman applying for or receiving benefits under any COA other than RSM PgW who is in the second trimester of pregnancy is not required to apply for UCB.
- Family Medicaid COAs do not require application for SSI.
- Applications for other benefits that would result in an overall reduction of current income are not required.

NOTE: Advise the applicant of potential benefits, even if application is not required.

Failure or refusal to apply for and accept other benefits results in ineligibility for ABD Medicaid COAs.

Failure or refusal to apply for and accept other benefits results in the following actions for Family Medicaid COAs:

- If the potential benefit is for a parent, exclude the parent and everyone for whom s/he is financially responsible.
- If the potential benefit is for a child, exclude only the child.

BASIC CONSIDERATIONS (cont.)

An individual in a Family Medicaid COA who fails to apply for other benefits may be eligible for another Family Medicaid COA in which the application for other benefits is not required. Complete a CMD prior to denial or termination of Medicaid and document the results of the CMD.

The A/R must apply for the highest possible benefit for which s/he is eligible. The A/R must also accept a benefit for the earliest month it is available.

AU members are required to apply for UCB only if Clearinghouse indicates potential eligibility.

Application for VA Compensation or VA Pension must be made by individuals who may be eligible for either benefit. VA Pension applicants may choose either to project estimated medical expenses (prospective) or claim medical expenses for the past year (retrospective).

EXCEPTION: A/Rs who are currently receiving a VA Pension do not have to file a special application for the New Improved Pension.

Benefits and income are not synonymous terms. Benefits include, but are not limited to the following:

- UCB/Severance Pay
- annuities
- disability payments, including RSDI, SSI and Worker's Compensation
- pensions
- unprobated estates

Benefits do **NOT** include the following:

- alimony
- child support
- Medicare
- payments on loans or promissory notes
- rent

BASIC CONSIDERATIONS (cont.)

The A/R is **NOT** required to apply for the following benefits:

- TANF
- benefits from a trust over which the A/R has no control
- Earned Income Credit (EIC)
- non-receipt of court ordered child support/alimony
- Prouty (Special Age 72) RSDI benefits
- Veterans Aid and Attendance
- Veterans Household Allowance
- Widow(er)'s Year's Support

NOTE: Refer to Section 2400, Income, for more detailed information about specific types of income.

PROCEDURES

Determine those benefits to which the A/R may be entitled by interviewing the A/R about employment history, military service, etc., of the applicant, AU members and any person through whom the applicant or AU members may be entitled (i.e., spouse or parent).

Advise the applicant or representative of other benefits to which the AU may be entitled and refer the A/R to the appropriate agency to apply.

Assign a reasonable deadline for the A/R to make application for the other benefits and to provide verification that the application was made.

Verify with one of the following:

- approval letter
- denial letter
- documentation verifying proof of application
- contact with the agency where the application was filed.

Approve the application if the applicant is eligible on all other points of eligibility, even if the application for other benefits has not been approved or denied.

NOTE: Schedule an interim review to verify the status of the application for other benefits if the application is still pending at time of approval.

Exclude an adult and anyone for whom s/he is responsible if the adult fails or refuses to apply for other benefits. If the other benefits are for a child, exclude only that child.

NOTE: For Family Medicaid COAs, accept the applicant's statement that s/he intends to apply for other benefits.

PROCEDURES (cont.)

Documentation

Document the case record to indicate that an AU member must apply for other benefits, if applicable to the COA. Document the deadline by which this must be done, verification used, if required, and the effect on the eligibility of the AU.

2215 – CITIZENSHIP AND ALIENAGE

POLICY STATEMENT

An individual must be a U.S. citizen or establish INS status as an alien lawfully admitted for permanent residence in order to be eligible for Medicaid.

EXCEPTION: An individual determined ineligible for Medicaid solely because of not meeting the citizenship (alienage) requirement is potentially eligible for Emergency Medical Assistance. Refer to Section 2054, Emergency Medical Assistance (EMA).

Alien status determines the benefits to which an alien may be entitled. Citizenship/alienage status does not have to be established for a child under Newborn Medicaid or for an individual receiving EMA.

BASIC CONSIDERATIONS

A U.S. citizen is an individual who is one of the following:

- Born in one of the 50 states, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands (St. Thomas, St. Croix and St. John), Northern Mariana Islands (Saipan, Rota and Tinian), American Samoa, or Swains Island.
- Minor child(ren) born in another country to a non U.S. citizen becomes a citizen when the parent resides in the U.S. for the required period of time and becomes a naturalized citizen.
- Born in another country to a U.S. citizen.

NOTE: Children born in another country to a U.S. citizen are U.S. citizens until age 18, when they must declare either U.S. citizenship or birth country citizenship.

Definition of Alienage

Aliens are individuals who are not U.S. citizens, but reside in the U.S. or its territories. Visitors, tourists, foreign students and diplomats are not eligible for benefits.

Alien status determines the benefits to which an alien may be entitled. Any alien who entered the U.S. on or after August 22, 1996, is not eligible for Medicaid for any class of assistance for a period of five years from the date of entry into the U.S., unless s/he is a Qualified Alien and meets one of the criteria listed in Chart 2215.1.

Any alien, who entered the U.S. for permanent lawful residence prior to August 22, 1996, continues to meet the citizenship/alien criteria for any Family Medicaid or ABD Medicaid COA.

Any alien who has entered the U.S. for permanent lawful residence prior to August 22, 1996, and is not potentially eligible for SSI based on the criteria in Chart 2215.1 can be determined eligible for ABD Medicaid under any appropriate COA, including AMN.

BASIC CONSIDERATIONS (cont.)

For Family Medicaid, any assistance unit (AU) member who fails or refuses to cooperate in determining citizenship/alienage status is ineligible. Refer to Chapter 2650, Family Medicaid Budgeting.

Individuals who are not recipients of Medicaid but who are Medicaid budget group members only do not have to meet the citizenship/ alienage requirements.

Definition of Qualified Alien

According to the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, a Qualified Alien is an alien who, at the time the alien applies for, receives or attempts to receive a Federal public benefit, such as Medicaid, is:

- an alien who is lawfully admitted for permanent residence under the INS, whose departure from the U.S. INS does not contemplate enforcing. An alien is considered to be permanently residing when INS has granted permission to remain in the U.S. for an indefinite period of time. This is referred to as PRUCOL and this designation does not always remain the same. INS can withdraw permission to remain and enforce deportation proceedings,

OR

- an alien granted asylum under Section 208 of such Act,

OR

- an alien granted a status as a Cuban-Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980),

OR

- a refugee admitted to the U.S. under Section 207 of such Act,

OR

- an alien paroled unto the U.S. under Section 212(d)(5) of such Act for a period of at least one year,

OR

- an alien whose deportation is being withheld under Section 243(h) of such Act,

OR

- an alien granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980.

PROCEDURES (cont.)

Establishing Citizenship

Accept the A/R's statement of U.S. citizenship unless questionable or information known to the agency conflicts with that statement.

Establish citizenship/alienage at the following times:

- at initial application
- when an individual is added to the AU
- when the agency becomes aware of a discrepancy

Verification

If questionable, verify citizenship with one of the following:

- birth certificate
- U.S. passport
- Report of Birth from Abroad of a U.S. Citizen (Form FS-240)
- Certificate of Birth (Form FS-545)
- U.S. Citizen ID card (I-97)
- Naturalization Certificate (N-550)
- Certificate of Citizenship (N-560)
- SSN issue prior to 6/30/48
- prior entitlement to SSI
- any document over 5 years old showing place of birth
- any document over 5 years old that shows U.S. residency prior to 6/30/48
- the written statement of a person in a position to have knowledge of an individual's place of birth (to be used only for an individual born in the U.S. when no other method of verification is available).

Document the following:

- the A/R's statement is accepted, or
- the source of verification used.

PROCEDURES (cont.)

Verifying Alien Status

Verify INS alien status for each alien AU member. Use INS documents and Chart 2215.1 to determine alien status and potential eligibility for benefits.

Exclude undocumented aliens. Additional documents may be requested from INS only with the alien's written permission. Reconsider an alien for inclusion in the AU if INS alien status verification is later received. Refer to Chapter 2500 ABD Responsibility Budgeting, Chapter 2600 Family Medicaid AUs/BGs and Chapter 2650 Family Medicaid Budgeting.

SAVE procedures are completed for potentially eligible aliens.

Verify eligible alien status at the following times:

- at application
- when an individual is added to the AU
- when the agency becomes aware of a discrepancy

Document the following:

- AU's statement of alien status
- source of verification
- SAVE verification

Systematic Alien Verification Entitlement (SAVE)

Systematic Alien Verification for Entitlement (SAVE) procedures establishes the legitimacy of an alien's document.

Complete SAVE procedures in the following situations:

- to verify alien status when the document is not on the chart,
- to establish the legitimacy of an alien's document,
- to determine if INS has assigned a new alien status, particularly if the document has expired,
- to verify the status of an alien if the alien document is lost

Follow the steps below to complete the SAVE process:

Step 1 Determine if the alien is an eligible alien using chart 2215.1.

Step 2 If the alien is ineligible for Medicaid, do not continue with SAVE.

If eligible or eligibility is questionable, complete the Form G-845 and copy both sides of the alien's document.

PROCEDURES (cont.)

Step 3 Dial the SAVE ASVI system at 800-365-7620.

Step 4 The Voice Output System will ask for your access code. For Medicaid enter *42*61*41*210001#.

Step 5 The Voice Output System will instruct you to enter the alien registration number (the number beginning with an A).

IMPORTANT: Instead of entering an A on a touch-tone phone, enter a zero. If the alien registration number beings with zero, do not enter the additional zero.

Step 6 Record the verification number on the G-845, as indicated by the Voice Output System. File the Form G-845 in the case record.

Step 7 If the Voice Output System indicates that secondary verification is required, mail the Form G-845 and documentation to the following address and document the case accordingly:

Immigration and Naturalization Service
Russell Federal Annex Building
77 Forsyth Street, Room 85
Atlanta, GA 30303
Attention: Status Verifier (No. 26)

Continue with the eligibility determination while waiting for secondary verification. Allow timely notice and terminate Medicaid if secondary verification indicates the alien unqualified. Consider EMA.

Determining 40 Qualifying Quarters

Lawful permanent residents who can be credited with 40 qualifying quarters of employment meet the citizenship/alienage requirement for an unlimited period.

To establish 40 qualifying quarters complete the following process:

Step 1 Obtain the name, SSN, date of birth and gender of each wage earner whose quarters are being used to establish eligibility.

The wage earner may be:

- the alien (self)
- a current spouse (consider only quarters worked during the marriage)
- a deceased spouse whose credited quarters were worked during the marriage

NOTE: The alien may not be currently married if considering a deceased spouse's qualifying quarters

PROCEDURES

Determining 40 Qualifying Quarters (cont.)

- A parent (deceased or divorced) whose children (biological or adopted) are/were under age 18 at the time the credited quarters are/were worked.

  NOTE: Quarters earned prior to birth of the child may be used.

- A stepparent if at the time the credited quarters were worked the child was under age 18, unmarried and there was a marital relationship with the child's parent

  NOTE: If the marital relationship ends for reasons other than death, credited quarters of a stepparent cannot be used.

  NOTE: A child's quarters of employment cannot be used by a parent to meet this requirement.

Step 2 Accept the A/R's or wage earner's statement of quarters worked if:

1. Alone or in combination with parents and/or spouse the alien has sufficient time in the U.S. to have acquired 40 quarters;
2. INS documents verify that the dates of entry are consistent with 40 credited quarters or more;
3. The alien, spouse, parent or a combination of these individuals has sufficient quarters to meet the requirement. The same quarters may be used to meet the requirement for more than one alien.

Use the SVES system in SUCCESS to interface with the Social Security Administration (SSA) to obtain verification needed to credit quarters. Refer to the SUCCESS User Manual.

Step 3 Have each wage earner whose quarters are being used to establish eligibility complete and sign Form SSA-3288, Social Security Administration Consent for Release Information, and to provide a statement if his/her work history as outlined in Step 2.

NOTE: The wage earner may be an alien or U.S. citizen by birth or naturalization. The wage earner does not have to have paid Social Security taxes or have earned quarters under the SSA.

Step 4 Exclude as a credit quarter any quarter in which the wage earner received federal public assistance on or after January 1, 1997. The resulting total qualifying quarters and must equal or exceed 40 for the lawful permanent resident to be eligible for benefits.

NOTE: "Received" is defined as being included in federal public assistance.

PROCEDURES

Determining 40 Qualifying Quarters (cont.)

Public assistance is defined as Food Stamp benefits, housing, TANF, employment services, support services, child care subsidy, federal energy assistance, subsidized utilities, SSI or Medicaid (other than EMA). This list is not all-inclusive.

Public assistance does not include EMA, public health assistance, foster care, adoption assistance, soup kitchen meals, crisis counseling, short term shelter, educational assistance, WIA, disaster relief or Head Start This list is not all-inclusive.

Step 5 Determine the number of credited quarters, as follows:

- Prior to 1978 –

  If earnings totaled at least $50 per calendar quarter (January through March, April through June, July through September or October through December), a quarter was credited to the wage earner.

- Effective January 1, 1978 –

  Credited quarters are based on the total yearly earnings. To determine the number of credited quarters, divide the total yearly earnings by the figures listed below for that year. The result (up to 4), minus the number of quarters public assistance was received, is the number of credit quarters.

1978	$250	1990	$520
1979	$260	1991	$540
1980	$290	1992	$570
1981	$310	1993	$590
1982	$340	1994	$620
1983	$370	1995	$630
1984	$390	1996	$640
1985	$410	1997	$670
1986	$440	1998	$700
1987	$460	1999	$740
1988	$470	2000	$780
1989	$500	2001	$830

Step 6 Document calculations in the case record.

SPECIAL CONSIDERATIONS

Use of a Social Security Number to Verify Citizenship

A Social Security Number (SSN) issued prior to June 30, 1948 may be used to verify citizenship if the A/R's citizenship is questionable and no other evidence is available.

Follow the steps below to determine if the A/R's SSN was issued prior to June 30, 1948:

Step 1 Determine the Area and Group numbers included in the A/R's SSN. The first three digits of the SSN are the Area number, and the fourth and fifth digits are the Group number.

Step 2 Locate the A/R's Area number on the Evidence of Citizenship Chart found on the following page.

Step 3 Compare the A/R's Group number to the highest Group number issued for the A/R's Area number as listed on the chart.

Step 4 If the A/R's Group number falls within the range of Group numbers issued for the A/R's Area number prior to June 30, 1948 use the SSN as verification of citizenship.

If the A/R's Group number **does not** fall within the range of Group numbers issued for the A/R's Area prior to June 30, 1948 require the A/R to provide other verification if citizenship is questionable.

EVIDENCE OF CITIZENSHIP CHART

Highest Group numbers in each Social Security Number area issued prior to June 30, 1948:

Area	Group	Area	Group	Area	Group	Area	Group
001	22	221	18	393	26	494-500	30
002-003	20	222	16	394	24	501	24
004-005	28	223-224	36	395-396	26	502	22
006-007	26	225-231	34	397-398	24	503	26
008-009	18	232	46	399	26	504	24
010-015	24	233-236	44	400-404	36	505	32
016	22	237-238	42	405	34	506-508	30
017-018	24	239-246	40	406	36	509-514	26
019-034	22	247-248	44	407	34	515	24
035-037	20	249-252	42	408-409	46	516-518	30
038-039	18	253-254	44	410-414	44	519-520	28
040-042	24	261-266	40	415	42	521	36
043-049	22	267	38	416-420	36	522-524	34
050-056	24	268-287	26	421-424	34	525	36
057-058	22	288	24	425-431	50	526-529	34
059-071	24	289-296	26	432	46	530	16
072	22	297	24	433	42	531-532	28
073-081	24	298-299	26	434-439	40	533-539	26
082	22	300-302	24	440-444	28	540-541	32
083-086	24	303-307	30	445	26	542-544	30
087-088	22	308	28	446-448	28	545-559	38
089	24	309	30	449-459	44	560-561	36
090-098	22	310-317	28	460	42	562-567	38
099	24	318-356	24	461	44	568	36
100-134	22	357-358	22	462-463	42	569-571	38
135-136	24	359	24	464	44	572	36
137-158	22	360-361	22	465-467	42	573	38
159-185	24	362-363	30	468-472	30	574	07
186-211	22	364-377	28	473-477	28	575-576	26
212-213	28	378	26	478-485	30	577-578	40
214	26	379-386	28	486-489	32	579	38
215	28	387-391	26	490	30		
216-220	26	392	24	491-493	32		

SSN's are issued in the following order:

1. Odd numbered groups 01-09;
2. Even numbered groups 10-98;
3. Even number groups 02-08;
4. Odd numbered groups 11-99.

Each group is exhausted before the following group is issued. Thus, in area 237 groups 01-09 and 10-42 had been issued by 06-30-48.

The chart below provides each INS status, which is routinely applicable to eligibility determinations. This chart is not all-inclusive. The INS has the discretion to change documents or codes to allow any alien or group of aliens to stay in the U.S. for an indefinite period. Service agencies may not be aware of these changes prior to implementation.

Additionally, documents issued by the INS vary by local INS office. For example, two aliens with the same immigration status may not have the same document to verify the same status. Letters of decision from immigration judges may identify INS status, also. Direct questions regarding documents to the appropriate policy help desk.

CHART 2215.1 – DETERMINATION OF ALIEN STATUS

IF the A/R's Alien INS status is:	**THEN the A/R meets the Citizenship/Alien eligibility criteria for the following COAs:**	**Verify with one of the following INS documents:**
Lawful Permanent Resident with 40 qualifying quarters of coverage who enters the U.S. • prior to 8/22/96	SSI, Any Family Medicaid or ABD Medicaid COA.	Resident Alien Card Passport, Visa, I-94, I-181, INS AR-3a or other INS documentation stating the "Processed for I-551, Temporary Evidence of Lawful Residence"
• on or after 8/22/96	EMA for 5 years beginning with date of entry. Any Family Medicaid or ABD Medicaid COA beginning 5 years from the date of entry.	
Lawful Permanent Resident without 40 qualifying quarters of coverage who entered the U.S. • Prior to 8/22/96	Any Family Medicaid or ABD Medicaid COA.	
• On or after 8/22/96	Any Family Medicaid or ABD Medicaid COA beginning 5 years after the date of entry. Exception: EMA eligible beginning from the date of entry. No waiting period applies.	

CHART 2215.1 – DETERMINATION OF ALIEN STATUS (cont.)

IF the A/R's Alien INS status is:	THEN the A/R meets the Citizenship/Alien eligibility criteria for the following COAs:	Verify with one of the following INS documents:
Lawful Permanent Resident who was lawfully residing in U.S. on or prior to 8/22/96 and who is or becomes disabled or blind	SSI, Any Family Medicaid or ABD Medicaid COA.	Resident Alien Card Passport, Visa, I-94, I-181, INS AR-3a or other INS documentation bearing the endorsement "Processed for I-551, Temporary Evidence of Lawful Residence"
Lawful Permanent Resident who was lawfully residing in U.S. on or prior to 8/22/96 and was 65 years or older at that time	Ineligible for SSI unless they meet disability criteria or have 40 qualifying quarters. Refer to SSA to make application for SSI if appropriate. Eligible for any ABD Medicaid COA based on age.	
Any SSI recipient who applied for SSI before 1979	SSI , Any ABD Medicaid COA	Any INS status or documentation that establishes the alien as having applied for SSI prior to 1979
An alien granted asylum status under Section 208 of INA who entered the U.S. - Prior to 8/22/96	Any Family Medicaid or ABD Medicaid COA OR SSI for 7 years from date asylee status is granted, regardless of current INS status	I-94 annotated with Section 208 I-688B annotated with 274a.12 (a) (5) Other INS documents with asylum codes of AS1, AS2, AS3 AS6, AS7, AS8
- On or after 8/22/96	Any Family Medicaid or ABD Medicaid COA OR SSI for 7 years from date asylee status is granted, regardless of current INS status	
An American Indian born outside the US, but recognized as a Lawful Permanent Resident if living along the Canadian border	SSI OR Any Family Medicaid or ABD Medicaid COA	Same as above or 50% blood is that of an American Indian or is a member of a federally recognized tribe.

CHART 2215.1 – DETERMINATION OF ALIEN STATUS (cont.)

IF the A/R's Alien INS status is:	THEN the A/R meets the Citizenship/Alien eligibility criteria for the following COAs:	Verify with one of the following INS documents:
An alien paroled for at least one year under Section 212(d)(5) who entered the U.S. - prior to 8/22/96	Any Family Medicaid or ABD Medicaid COA	I-688B annotated with 274a.12(a) (4) or c(11) I-94 annotated with 212(d)(5an)
- on or after 8/22/96	Any Family Medicaid or ABD Medicaid COA beginning 5 years from the entry date EXCEPTION: EMA for 5 years beginning from the date granted parolee status	I-512 annotated with Section 212(d)(5)
A Cuban and Haitian entrant admitted under Section 501(3) of Refugee Education Assistance Act of 1980 (as of 11/98)	SSI for 7 years from date of entering into U.S. OR Any Family Medicaid or ABD Medicaid COA	I-94 annotated with paroled as refugee, Section 207 or married Cuban I-551 or I-151 with CH6, CNP, CU6 or 7
An immigrant with Amerasian INS status who entered the U.S. either prior or on or after 8/22/96.	SSI for 7 years from date of entry into the U.S. regardless of current status OR Any Family Medicaid or ABD Medicaid COA	I-95 annotated with AM1, AM2, AM3 I-551 annotated with AM6, AM7, AM8 Vietnamese Exit Visa, Vietnamese Passport, or U.S. Passport stamped AM1, AM2, AM3
Any above listed alien and considered a battered spouse or child and who is no longer living with the batterer.	Any Family Medicaid or ABD Medicaid COA	Any INS document that established a spouse or child(ren) as lawfully residing in the U.S. and considers them as a battered spouse or child(ren).

CHART 2215.1 – DETERMINATION OF ALIEN STATUS (cont.)		
IF the A/R's Alien INS status is:	**THEN the A/R meets the Citizenship/Alien eligibility criteria for the following COAs:**	**Verify with one of the following INS documents:**
A qualified alien with any documented status if the alien is: • a veteran who has been honorably discharged for reasons other than alienage, OR • on active military duty (other than active duty for training) AND • the qualified alien spouse and unmarried children (natural, adoptive or step) under 18, of the veteran or military personnel on active duty	SSI OR Any Family Medicaid or ABD Medicaid COA	Any INS document that establishes that the alien is lawfully residing in the U.S. (Spouse and any unmarried children [natural, adoptive, or step] under 18, must also be documented as lawfully residing in the U.S.
A refugee admitted under Section 207 of Immigration & Naturalization Act (INA)	SSI for 7 years from date of entry into U.S., regardless of current status OR Any Family Medicaid or ABD Medicaid COA	
Alien whose deportation is being withheld under Section 243(h) or 241(b) of the INA	SSI for 7 years from date of withholding deportation OR Any Family Medicaid or ABD Medicaid COA	I-94 annotated with Section 243(h) Other INS documentation from an immigration judge showing that deportation has been withheld
Conditional entrants under Section 203(a)(7) of the INA in effect prior to 4/1/80 who entered the U.S. - Prior to 8/22/96 - On or After 8/22/96	Any Family Medicaid or ABD Medicaid COA EMA for 5 years beginning from the date of entry THEN Any Family Medicaid or ABD Medicaid COA	I-94 annotated with Section 203(a)(7)
All other aliens	Any Medicaid COA using EMA procedures	N/A

2220 - ENUMERATION

POLICY STATEMENT

Each applicant and Assistance Unit (AU) member must provide or apply for a Social Security Number (SSN) in order to receive Medicaid.

BASIC CONSIDERATIONS

Enumeration is the process by which a SSN is obtained and validated.

SSNs are used to secure information from other sources to achieve the following:

- complete reviews necessitated by federal benefit changes
- discover unreported income or resources
- prevent duplicate benefits
- verify reported information.

An attempt should be made to obtain the SSNs of non-AU individuals whose income and/or resources are considered in determining eligibility. Eligibility is **not** adversely affected if the applicant fails to furnish the SSN of a non-AU individual unless eligibility cannot be established.

NOTE: Benefits will not be denied during the application for, or the validation of, a SSN.

Refusal to be enumerated results in denial of the Medicaid application.

EXCEPTION: Enumeration is not required for Emergency Medical Assistance (EMA) and Newborn Medicaid COAs.

The A/R's verbal or written statement of the SSN, intent to apply or that s/he has applied for the SSN of an AU member meets the enumeration requirement. If the A/R's statement of intent to apply or that s/he has applied for a SSN is accepted (not questionable), follow-up is required in the third month after the month of approval. If the SSN or verification of an application for a SSN is not received within 30 days of the follow-up request, the individual is not eligible for Medicaid unless Good Cause is established. Refer to Good Cause and Chart 2220.2 in this Section.

TMA/4MCS

A LIM AU member who complied with the enumeration requirement by agreeing to apply for a SSN or by establishing Good Cause is no longer required to comply following approval for TMA or 4MCS.

BASIC CONSIDERATIONS (cont.)

Newborn Medicaid and EMA

Compliance with the enumeration process is not required for Newborn Medicaid, Family Medicaid EMA and ABD EMA.

Good Cause

Good Cause may be established for failure to meet the enumeration requirement. Refusal to meet the requirement without Good Cause results in an automatic determination of non-compliance.

Good Cause is established when it is determined that the AU member has made every effort to obtain a SSN but has been unsuccessful. The agency must make every effort to assist the AU in obtaining documents needed to complete the enumeration process.

Good Cause includes, but is not limited to the following:

- documentary evidence or collateral information that the AU member has applied for a SSN and has not yet been issued a number
- the inability of the AU to obtain the necessary documents required by the Social Security Administration (SSA). Example: inability to obtain a birth certificate.

Good Cause does **NOT** include the following:

- lack of transportation
- temporary absence from the home
- age/illness/infirmity

NOTE: The eligibility worker must provide assistance to the A/R in obtaining information required to meet the enumeration requirement.

PROCEDURES

Use the following chart to determine the procedures for obtaining and validating a SSN in specific situations.

CHART 2220.1 – ENUMERATION

IF the A/R	THEN
is currently in the system with a SSN	document the SSN. Compare known SSN with the A/R's statement. The SSN will be verified through the validation process.
knows the SSN at the interview	document the SSN. Enter the SSN into the system. Place copies of available SSN cards in the permanent verification section of the case record.
does not know the SSN at the interview but can provide it	request that the SSN be provided within 12 days. Issue the verification checklist. Document the SSN when it is provided. Enter the SSN in the system.
has multiple SSNs	refer the A/R to the Social Security Administration (SSA) to determine the correct SSN. Document all known SSNs. Inform the A/R of the responsibility to report the correct and primary SSN to the county office upon resolution with SSA. Refer to the chart entitled System Related Enumeration Problems if appropriate.
is enumerated at birth by a medical facility	accept client statement, unless questionable. Contact the A/R no later than the fifth month following the month of application for the SSN to determine if the SSN has been received. If the SSN has not been received, contact the A/R monthly thereafter.

CHART 2220.1 – ENUMERATION (CONT.)

IF the A/R	THEN
never had a SSN OR had a SSN but the number is unknown or cannot be located	refer the AU member to SSA to apply for a new or replacement SSN. Follow these steps: 1. Inform the AU of the responsibility to submit original or certified copies of documents that verify age, identity, and citizenship (e.g., birth certificates, driver's licenses, etc.) to SSA with the application for a SSN. 2. Complete Form 189, Referral for SSN Application, or print a system-generated Referral for SSN Application and include the client ID of the individual who must be enumerated. 3. Provide the AU with copies of Form 189 or a system-generated referral to take to SSA. Retain a copy of the referral for the case record. 4. Obtain the A/R's verbal or written statement that s/he has applied for will apply for a SSN for the AU member. Document the A/R's statement. 5. Contact the A/R in the third month after the month of approval to obtain the SSN or verification of the application for a SSN. 6. Allow 30 days from the date of request for the A/R to provide the SSN or verification of the application for a SSN. 7. Document the SSN, file verification of the application in the case folder. OR determine if Good Cause exists if the requirement is not met. 8. If Good Cause exists, contact the AU monthly to monitor Good Cause. If Good Cause does not exist, the non-enumerated individual is not included in the AU. 9. Request the SSN at the next review if it has not been provided. If the SSN has not been received by the next review, request the SSN at each review thereafter.

NON-COMPLIANCE WITH ENUMERATION PROCESS	AU members who fail or refuse, without Good Cause, to complete the enumeration process are not eligible to be included in a Family Medicaid or ABD AU.
LIM	A parent who does not meet the Medicaid enumeration requirement is penalized and his/her needs are not considered in determining LIM eligibility. Refer to Chapter 2650, Family Medicaid Budgeting for budgeting procedures for a penalized individual.
RSM and Family Medicaid Medically Needy	A pregnant woman who does not meet the enumeration requirement is ineligible. If the pregnant woman has a child for whom RSM or FM-MN eligibility is being determined, she is included in the BG. The unborn child is not included in the BG. A child who does not meet the enumeration requirement is ineligible. The child may be included in or excluded from the BG at the option of the A/R. A parent who does not meet the enumeration requirement is included in the BG with his/her child(ren) for whom RSM or FM-MN eligibility is being considered. A non-parent relative who does not meet the enumeration requirement is excluded from the BG.
CWFC Medicaid	A CWFC child who does not meet the enumeration requirement is ineligible.
COMPLIANCE	The individual is added to the AU the month the requirement is met or Good Cause is established.

Use the following chart to determine required action when Good Cause is established or the enumeration requirement is met following non-compliance.

CHART 2220.2 - GOOD CAUSE IN ENUMERATION	
IF	**THEN**
Good Cause is established at application processing OR Good Cause is established when an individual joins the AU	document the following: • the AU's statement of the reason for non-compliance • the reason for establishing Good Cause • the offer of assistance in obtaining needed verification. Include the individual in the AU and/or BG. Monitor Good Cause assertion on a monthly basis by the following methods: • contact the A/R in writing, in person, or by telephone AND • document the current status of the Good Cause determination.
the non-enumerated individual meets the enumeration requirement OR establishes Good Cause	document that the enumeration requirement has been met. Add the individual to the AU/BG the month in which the requirement is met or Good Cause is established.
Good Cause assertion is denied at application processing	document the following: • the AU's statement of the reason for non-compliance • the reason for denial of the Good Cause claim • the offer of assistance in applying for a SSN Complete the application. Do not include the non-enumerated individual in the AU. Refer to Chart 2220.1. Issue a notice to the AU. Include the following information in the notice: • the reason for the action • the eligibility of the remaining AU members • the action the individual must take to be added to the AU.

CHART 2220.2 – GOOD CAUSE IN ENUMERATION (CONT.)	
IF	**THEN**
Good Cause assertion is denied when an individual joins the AU	document the following: • the AU's statement of the reason for non-compliance • the reason for denial of the Good Cause claim • the offer of assistance in applying for a SSN Do not include the non-enumerated individual in the AU. Issue a notice to the AU. Include the following information in the notice: • the reason for the action • the eligibility and benefit level of the remaining AU members • the action the individual must take to be added to the AU.
AU member initially complies with enumeration but refuses to resolve discrepancies identified during the SSA validation process	document the following: • the AU's statement of the reason for non-compliance • the reason for denial of the Good Cause claim • the offer of assistance in applying for a SSN Do not include the non-enumerated individual in the AU. Issue a notice to the AU. Include the following information in the notice: • the reason for the action • the eligibility and benefit level of the remaining AU members • the action the individual must take to be added to the AU.
AU member is currently receiving benefits OR Good Cause for non-compliance no longer exists	document the reason Good Cause no longer exists. Issue a timely notice to the AU. The notice must include the following information: • the reason for the action • the eligibility of the remaining AU members • the action the individual must take to be added to the AU. Remove the non-enumerated individual from the AU effective the month following the month timely notice expires. (Refer to Chart 2220.1.)

Use the following chart to determine the procedures for various situations related to problems with SSNs.

CHART 2220.3 – SYSTEM RELATED ENUMERATION PROBLEMS	
IF the A/R's SSN	**THEN**
appears on the system generated SSN discrepancy listing	research the case record to determine if the information regarding the A/R's full name, DOB, and SSN matches information on the A/R's official documents. Correct any information that is found to be in error. Refer the client to SSA for corrective action if the SSA information is found to be the source of the error.
matches with another SSN known to the system	screen and research both SSNs to determine which number on the system is correctly assigned. **NOTE:** Contact with another DFCS office/county may be necessary. Take action to have any erroneously entered SSNs corrected in the system. OR refer the A/R to SSA for corrective action if multiple individuals are verified to have been assigned the same SSN.
is incorrect and is validated by the system	contact the system Problem Resolution Unit for corrective action via e-mail, PA.PROBLEM3.

SSN VALIDATION

POLICY STATEMENT	The system interfaces with the files at the Social Security Administration (SSA) to verify the accuracy of the SSN of an AU member.
PROCEDURES	Follow the procedures in Chart 2220.4, SSN Validation, to complete validation requirements.

CHART 2220.4 - SSN VALIDATION

IF an AU Member's SSN	THEN
is valid	the system will annotate the SSN with a FV. No further action is required.
appears on the system generated enumeration or validation discrepancy lists	determine if the AU member's full name, DOB and SSN matches information on the individual's official documents. Correct any information that is in error. Refer the A/R to SSA for corrective action if the SSA information is the source of the error.
matches with another SSN known to the system	determine which number on the system is correctly assigned. Correct any SSNs erroneously entered in the system OR Refer the AU member to SSA for corrective action if multiple individuals are assigned the same SSN.
is validated by the system but differs from verification (SSN card) obtained from the A/R	follow the steps below to correct the error.

PROCEDURES (cont.)

How to Change a Validated SSN

Step 1 Gather the following case identifying information and report it in the order listed:

- worker's name
- worker's telephone number
- county, office, supervisor, load number
- AU number
- AU name
- AU member's name
- AU member's ID number

Step 2 Route the above information to the following address:

Information and Technology (IT)
Two Peachtree Street, NW
Room 25-205
Atlanta, Georgia 30303
Attn: SSN Validation

OR

Send an e-mail message with the above information to e-mail ID PA.Problem3.

Step 3 Correct the SSN when IT provides notification that the validation code has been removed.

2225 – RESIDENCY

POLICY STATEMENT	The A/R member(s) must be a resident of Georgia in order to be eligible for Medicaid.
BASIC CONSIDERATIONS	The A/R must live or intend to live in Georgia indefinitely. There is no specific durational requirement but the A/R may not be in Georgia for a visit. The A/R does not have to live in Georgia on the first day of the month or live in Georgia for any certain number of days during the month in order to be considered a Georgia resident. If the A/R has been out of the country for any period of time, s/he can begin receiving Medicaid benefits immediately upon return if all eligibility criteria are met. If an A/R receives a Medicaid card in another state for a particular month and applies for Medicaid in Georgia later in the same month, the A/R is considered a Georgia resident that same month if s/he intends to remain in Georgia indefinitely. S/he is potentially eligible for Medicaid in Georgia for that month. The place of residence need not be a fixed dwelling.
PROCEDURES	Use the following guidelines to determine the state of residence: For Family Medicaid COAs, a child is considered to be a resident of the state in which the parent or caretaker of the child resides. For ABD Medicaid COAs, a child applicant who is not in LA-D is considered to be a resident of the state in which s/he lives. If a child applicant is in LA-D, base the child's residency on one of the following: the state in which the parent(s) or guardian lives at the time of placement **OR** the current state of residence of the parent(s) or guardian if the child resides in LA-D in the same state **OR** the residence of the person who makes the application for the child if the child is abandoned (without a guardian) and lives in the same state.

PROCEDURES (cont.)

NOTE: Use an Interstate Residency Agreement (IRA) if possible to waive residency when it is determined that a LA-D child is a resident of a state other than Georgia. Refer to SPECIAL CONSIDERATIONS in this section.

Consider an adult applicant who is mentally capable to be a resident of the state, in which s/he lives and intends to remain indefinitely.

Adult Applicant who Became Mentally Incapable After Age 18

If an adult applicant became mentally incapable after age 18, consider the adult to be a resident of the state in which s/he is physically present.

Adult Applicant who Became Mentally Incapable Before Age 18

If an adult applicant who became mentally incapable before age 18 is **not** in LA-D, consider the adult to be a resident of the state in which s/he lives.

If an adult applicant who became mentally incapable before age 18 is in LA-D, use the rules for a LA-D child applicant to determine the state of residency, including use of an IRA.

NOTE: An applicant is never a Georgia resident if s/he is placed in a Georgia institution by an out-of-state state agency.

VERIFICATION

Establish Georgia residency at initial application.

Accept and document A/R's statement of residency unless information known to the agency conflicts with the A/R's statement.

Verify when questionable with one of the following:

- lease, rent or utility company receipts
- school records
- written statement of responsible reference
- any other document proving residency

Document the A/R's statement of residency and the source of verification , if required.

VERIFICATION (cont.)

For ABD Medicaid, if the A/R is mentally incapable of stating residency, verify and document mental incapability using any of the following:

- personal observation
- documentation on Form DMA-6
- a statement from a physician
- legal documentation of incompetency

For ABD Medicaid, also document a mentally capable adult A/R's statement of intent to remain in Georgia indefinitely.

SPECIAL CONSIDERATIONS

Interstate Residency Agreement (IRA) For ABD

Waive the Georgia residency requirement if the A/R who is determined to be a resident of another state meets the following conditions:

the applicant is placed in LA-D in Georgia
AND
the applicant is under age 18
OR
the applicant is age 18 or older but became mentally incapable prior to age 18
AND
Georgia has an IRA with the individual's state of residence.

Georgia has an IRA with the following states:

WV	AL	CA	MS	FL	MD	LA	TN	MN
KY	NM	NJ	OH	PA	WI	NC*	NY	

NOTE: Some of the other states with which Georgia has an IRA make the effective dates retroactive. Consequently, some individuals who applied for Medicaid who were determined ineligible due to residency may now be eligible for that period.

*The agreement with North Carolina covers only incapable individuals who reside in non-border institutions. Incapable individuals who enter a border institution which serves communities in both Georgia and North Carolina are the responsibility of the state in which they are determined to be a resident. A *border institution* is one located within forty miles of the Georgia/North Carolina state line.

2230 – THIRD PARTY RESOURCES

POLICY STATEMENT

Applicants for and recipients of Medicaid are required to provide information regarding third party resources (TPRs) available to AU members and must assign their rights to these TPRs to the Division of Medical Assistance (DMA).

BASIC CONSIDERATIONS

TPRs are medical benefits and include but are not limited to the following:

- CHAMPUS (active duty insurance)
- CHAMPVA (disabled veteran insurance)
- Court ordered payments of medical costs by an absent parent (AP)
- Court awards or trusts which provide for payment of medical expenses
- Health insurance policies (including the AP's)
  - private
  - indemnity
  - group
  - liability
- Medicare
- Worker's Compensation
- Special Needs Trusts or any trust or legal document that specifies monies are due to the State (this would include lawsuit settlements, workman's compensation settlements, etc.)

Recipients of Newborn Medicaid are not required to provide information regarding TPRs.

Payments from TPRs are assigned to DMA when the A/R signs the application form for Medicaid.

Form DMA-285, Health Insurance Information Questionnaire, transmits information about TPRs to DMA, along with a release of information statement and a statement of assignment of payments.

The Health Insurance Premium Purchase (HIPP) Referral Form transmits information to DMA for potential purchase of an A/R's health insurance. DMA will make the cost effective determination.

BASIC CONSIDERATIONS (cont.)

The Employer Statement of Available Insurance is a DMA form to accompany the HIPP referral when insurance is available for the A/R through an employer.

A/R must also provide information regarding a TPR held by an absent parent unless good cause is asserted and upheld. Good cause for refusing to cooperate is based on good cause standards for non-cooperation with the Office of Child Support Recovery

Applicants who refuse to cooperate in the TPR process without good cause or who refuse to enroll or who disenroll from health insurance which has been determined by DMA to be cost effective to purchase under the HIPP program are ineligible for Medicaid, beginning with the month of refusal or month of notification from DMA regarding HIPP.

Recipients who refuse to cooperate in the TPR process without good cause or who refuse to enroll or who disenroll from health insurance which has been determined by DMA be to cost effective to purchase under the HIPP program are ineligible, beginning with the month following the month of refusal or month of notification from DMA regarding HIPP.

SSI Recipients

SSI recipients who refuse to assign TPRs during the SSI application process are ineligible for Medicaid until TPR is assigned at the county DFCS office. Refer to Chart 2230.1 – TPR Reviews.

PROCEDURES

Use the following charts to determine what action to take in reviewing the TPR requirement at application, reviews and when a change in TPR occurs.

CHART 2230.1 – TPR	
If TPR is reviewed	**THEN**
at application AND the A/R has a TPR	complete Form DMA-285 for each TPR available to the A/R and submit the original form(s) to DMA, along with copies of any available documents verifying the TPR AND complete a DMA HIPP Referral Form and forward the original to DMA if the A/R has health insurance available OR complete Form 138 to document waiver of the TPR requirement because of Good Cause for non-cooperation with CSE or document as to why a HIPP referral was not made. **NOTE**: Do not submit Form DMA-285 to DMA if Medicare is the only TPR. **NOTE**: Do not make a HIPP referral under the following circumstances: • the only insurance is a Medicare Supplemental policy • the A/R will not be Medicaid eligible on an ongoing basis • the A/R is eligible for QMB, SLMB, QI-1 or QI-2 only.
at application AND there is no TPR available to the A/R	document appropriately. Form 285 is **not** required. OR complete Form 138 to document waiver of the TPR requirement because of Good Cause for non-compliance.
at a review	discuss TPR with the recipient. Document the system appropriately if there is no change.
when there is a change in TPR	complete a new Form DMA-285 to record any changes in an existing TPR or to report any new TPRs AND submit Form DMA-285 and/or HIPP Referral Form to DMA with the updated and/or new TPR information.
When a TPR has been canceled	submit a copy of the original Form DMA-285 and/or HIPP Referral Form to DMA with **CANCELED** written on the top in bold red letters. Include the date of cancellation, if available.
When a SSI recipient needs to assign TPR	follow the procedures used at application. Write **SSA Compliance** in red in the top right corner of the Form DMA-285 and submit it to DMA, even if Medicare is the only TPR.
When the TPR pays DMA more than the amount DMA paid for the service	DMA will issue a refund to the client and notify the county via the state office of the refund. Refer to Chapter 2400, Income for treatment of refunds from DMA.

PROCDURES
(cont.)

Trusts and Other Legal Documents	Any trust, such as a Special Needs Trust, or other similar legal document which contains a clause that provides for repayment of money to the state for medical treatment on behalf of an A/R is considered a TPR and is to be reported to DMA. Annotate Form 285 to indicate there is a trust document. Attach a copy of the trust or legal document and mail to DMA.

Form 285, Health Insurance Information Questionnaire, should be mailed to:

Public Consulting Group
5660 New Northside Drive
Suite 750
Atlanta, Georgia 30328

HIPP Referral Form should be mailed to:

DCH/HIPP Unit
P.O. 1500
Atlanta, Georgia 30301

SPECIAL CONSIDERATIONS

Payment From an Insurance Policy Based on Disability	If the A/R receives payments based on disability from an insurance policy, treat the payments as follows: If the payments are designated by the policy owner to cover medical expenses only, consider the payments to be a TPR. Report the payments to DMA on Form DMA-285. If the payments are designated to cover lost wages or to be used at the discretion of the policyholder (A/R), consider the payments to be unearned income if the payments cannot be assigned.

SPECIAL CONSIDERATIONS (cont.)

Do **NOT** make HIPP referrals on A/Rs:

- with no insurance or no access to insurance
- whose only insurance is a Medicare Supplement, indemnity* or cancer policy
- whose only insurance is through an HMO
- who are only eligible for QMB, SLMB, QI-1 or QI-2
- who do not have ongoing Medicaid coverage (no three month prior only)
- whose coverage is through an absent parent
- who are refugees
- when an employee pays 100% of the policy cost
- where no employer information is available (if applicable)
- when the name of the policy holder is not known
- when there is no known person to contact for referral

If an A/R has multiple health insurance policies, refer only the primary policy to HIPP.

*For example, an individual policy that reimburses a policyholder a set dollar amount for each day the policy holder is inpatient in an acute care facility should not be referred to the HIPP program.

A HIPP referral is not necessary for AMN A/Rs if spenddown is met at or near the end of a budget period. Refer AMN A/Rs when they will be defacto eligible for multiple budget periods.

2235 – LENGTH OF STAY FOR ABD MEDICAID

POLICY STATEMENT

Length of Stay (LOS) is a basic eligibility requirement for the following ABD Medicaid Cap Classes of Assistance (COA):

- Community Care Services Program (CCSP)
- Hospice Care
- Hospital
- Independent Care Waiver Program (ICWP)
- Nursing Home
- Mental Retardation Waiver Program (MRWP)
- Community Habilitation Support Services (CHSS)

An individual must remain in one of the above COAs for 30 continuous days to meet the LOS requirement.

BASIC CONSIDERATIONS

Once LOS is met, the Medicaid Cap is used to determine financial eligibility for each month the A/R resides in a Medicaid participating hospital or nursing home, or for each month the A/R receives either hospice services from an approved provider or a MRWP/CHSS, ICWP or CCSP waivered service.

The LOS requirement is **not** applicable to individuals already receiving Medicaid at the time of admission to one of the institutions or programs listed above.

NOTE: Individuals receiving only QMB, SLMB, QI-1 or QI-2 who enter one of these institutions or programs must meet the LOS requirement in order for the COA to be changed.

The LOS requirement is waived for individuals who die while residing in Living Arrangement D (LA-D). Refer to PROCEDURES in this section for a list of LA-D situations.

The LOS requirement can be assumed to have been met before 30 continuous days of confinement has elapsed in certain situations. Refer to Chart 2235.1 – Computing Length of Stay.

PROCEDURES

Compute the LOS by adding the continuous days of confinement in LA-D, including days of confinement from a month in which an individual is ineligible for Medicaid. The LOS requirement is met after 30 continuous days of LA-D confinement.

Consider the following to be LA-D confinement:

- Case management days in CCSP or ICWP
- Confinement in a Medicaid participating hospital or nursing home
- Enrollment in MRWP/CHSS
- Confinement in a non-Medicaid participating hospital or nursing home
- Confinement in an out-of-state medical institution
- Confinement in a state hospital
- Receipt of hospice services from an approved provider.

Always disregard the day of discharge when computing the LOS.

NOTE: If the LOS requirement is **not** met, complete a Continuing Medicaid Determination (CMD) to consider Medicaid eligibility under all COAs other than those using the Medicaid Cap.

PROCEDURES
(cont.)

Use the following chart to determine how to compute and verify the LOS requirement for specific situations:

CHART 2235.1 – COMPUTING LENGTH OF STAY		
IF the A/R is in	**THEN compute the LOS beginning with the day**	**AND the LOS requirement is**
CCSP	of admission to case management	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by a Form 5590, Community Care Communicator, from the CCSP case manager.
Hospice care at home or in a nursing home	of admission to hospice services	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by a Form 5590, Hospice Care Communicator (HCC), from the hospice care provider.
a hospital	of admission to a hospital	met after 30 continuous days of hospital confinement. Verify in writing or by a telephone contact with the hospital.
ICWP	of admission to case management services	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by an Independent Care Waiver Communicator from the ICWP case manager.
MRWP/CHSS	of admission to MRWP/CHSS (use enrollment date or date services begin)	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by an MRWP/CHSS Communicator from the CET.
a nursing home or hospital swing bed	of admission to a nursing home	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by Form DMA-59.
any combination of the above situations	of the first admission to LA-D, as long as the A/R goes directly from one LA-D to the other without interruption	met using the requirement for the COA under which ongoing eligibility is approved. Verify each of the admissions and discharges.

2240 – LEVEL OF CARE

POLICY STATEMENT

An approved level of care (LOC) is a basic eligibility requirement for the following ABD Medicaid classes of assistance (COAs):

- AMN Nursing Home/Hospice Care
- Community Care Services Program (CCSP)
- Deeming Waiver (Katie Beckett)
- Hospice Care
- Hospital
- Independent Care Waiver Program (ICWP)
- Model Waiver
- Nursing Home
- Mental Retardation Waiver Program (MRWP)
- Community Habilitation Support Services (CHSS)
- Swing Beds

BASIC CONSIDERATIONS

The Georgia Medical Care Foundation (GMCF) or other DMA approved agency determines the LOC for COAs requiring Form DMA-6, Physicians Recommendation. The CCSP Assessment Team on Form 5588 determines the LOC for CCSP.

For ABD Medicaid eligibility, LOC is defined as nursing facility care and is satisfied with placement in any approved level of nursing facility care.

Form DMA-6 will indicate approval for a specific level of nursing facility care Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF), ICF for the Mentally Retarded (ICF-MR) only for Medicaid reimbursement purposes.

The distinction between different levels of care is not relevant for Medicaid eligibility purposes.

Either a private pay or Medicaid Form DMA-6 is acceptable to determine LOC. A private pay Form DMA-6, however, is valid for only six months, beginning the month of admission.

GMCF or other DMA approved agency may approve a LOC for a specified number of days on Form DMA-6. Refer to Section 2577, Limited Stays, for procedures for a limited nursing home stay.

If a LOC is not approved, DMA is notified by the agency responsible for the decision. DMA then notifies DFCS of non-approval by letter. DFCS cannot approve Medicaid under a Medicaid Cap COA but must review eligibility under other COAs.

BASIC CONSIDERATIONS (cont.)

If an A/R is discharged from the NH, even if only to another COA (e.g. Hospice) while residing in the NH, a new DMA-6 is not required when the A/R is readmitted to NH COA, providing the limited stay date has not expired. However, a new DMA-6 is required upon readmission to the nursing home if the previous LOS has expired.

Use the following chart to determine how to obtain verification of LOC for each class of assistance:

CHART 2240.1 – VERIFYING LEVEL OF CARE

IF A/R is	THEN verify LOC by
in CCSP	page one of Form 5588, CCSP Level of Care and Placement Instrument, approved by the CCSP Assessment (A) Team for any level of nursing facility care. • The physician and A Team complete form 5588. • The A Team can approve a LOC for a CCSP stay of up to one year. The stay begins on the day Form 5588 is signed by the A Team. • If the A Team approves a LOC, the Team sends the approved Form 5588 to the CCSP Case Manager, who then sends DFCS a copy of page one of the form. • The A Team will review the LOC before the expiration date in Field 41, L.O.S., on Form 5588. The A Team will route a new Form 5588 to the case manager if the CCSP stay is extended based on the continuing need for a nursing home LOC. The CCSP case manager will send a copy of page one of the new Form 5588 to DFCS. **NOTE:** If page one of Form 5588 is not sent to DFCS within 30 days of the application date, follow up with the case manager by phone and in writing on Form 5590, Community Care Communicator.
in hospice care at home/or nursing home	receipt of a Hospice Care Communicator stating a prognosis of six months or less life expectancy. **NOTE:** Form DMA-6 is **not** required.
in a hospital	written or telephone contact with the hospital. **NOTE:** Form DMA-6 is **not** required
in ICWP	Form DMA-6 approved by GMCF for any level of nursing facility care. Obtain a copy of the approved Form DMA-6 from the ICWP case manager.
in MRWP/CHSS	Form DMA-6 approved by GMCF for any level of nursing facility care. Obtain a copy of the approved Form DMA-6 from the MRWP CET.

CHART 2240.1 – VERIFYING LEVEL OF CARE	
IF A/R is	**THEN verify LOC by**
in a nursing home	Form DMA-6 approved by GMCF for any level of nursing facility care. Form DMA-6 is completed by the physician and the Director of Nursing at the nursing home. The nursing home telephones GMCF to request prior approval, and then submits the Form DMA-6 to GMCF. If GMCF approves nursing facility care, GMCF sends the approved Form DMA-6 to DFCS. **NOTE:** If the Form DMA-6 is not received within 30 days of the application date, follow up by phone and in writing on Form 950, Facility Action Request.
in a swing bed	Form DMA-6 showing a skilled or intermediate LOC approval.
under Deeming Waiver or Model Waiver COA	Form DMA-6 approved by GMCF for any level of nursing facility care. Use the following procedures to obtain an approved Form DMA-6. • Write Deeming Waiver or Katie Beckett in red in the upper right hand corner of Form DMA-6 and enter the EW name and county DFCS return address in item 1. • Give the personal representative (PR) the Form DMA-6 to be completed by the child's physician. Require the PR or physician to return the form to DFCS for review. • Require the PR to obtain a psychological evaluation for any child with a diagnosis involving mental retardation (MR) or developmental delay (DD), including cerebral palsy, at initial application and every third annual review. The psychological evaluation may be completed by a Ph.D. psychologist, M.Ed., Child Development Specialist (Babies Can't Wait), Developmental Pediatrician or School psychologist. The psychological evaluation must have been completed within the past year. **NOTE:** A psychological evaluation completed within the past 3 years by a school psychologist is acceptable if the evaluation has been updated by the psychologist within the past year. • Complete a Form 188, Social Data Report, in detail on any child. A social data report from another social worker familiar with the situation is also acceptable. • Require the PR to obtain a daily care plan from the physician or primary care provider on any child at initial application and each annual review. • Attach any additional medical information (hospital admission/discharge summary) to the Form DMA-6, along with the care plan, Social Data Report and psychological evaluation, if applicable, and submit Form DMA-6 to GMCF at 57 Executive Park Drive, NE, Suite 200, Atlanta, GA 30329 **NOTE:** Form DMA-6 must reach GMCF before thirty days from the date of the physician's signature on the form. GMCF will return the Form DMA-6 to DFCS after making a decision on the LOC.

Use the following chart to determine the actions to be taken after GMCF makes a LOC determination.

CHART 2240.2 – ACTION AFTER A LOC DETERMINATION	
If GMCF	**THEN**
approves a LOC and sends an approved Form DMA-6 to the county DFCS	approve Medicaid under the appropriate COA upon completion of the eligibility determination. Refer to Section 2551, Patient Liability and Cost Share, and Section 2576, Vendor Payment Authorization, for instructions on the patient liability/cost share determination and vendor payment authorization.
approves a LOC for a limited stay and sends an approved Form DMA-6 to the county DFCS indicating a specified number of days	approve Medicaid under the appropriate COA upon completion of the eligibility determination. Refer to Section 2551, Patient Liability/Cost Share, for instructions on the patient liability/cost share determination. Authorize a nursing home vendor payment or CCSP/ICWP services only for the period of time indicated on Form DMA-6. Refer to Section 2577, Limited Stay.
does not approve a LOC and DMA notifies the county DFCS by letter	**do not** approve Medicaid under a Medicaid CAP COA. Complete a Continuing Medicaid Determination to review eligibility under all other COAs. Refer to Section 2052, Continuing Medicaid Determination.

2245 - LIVING WITH A SPECIFIED RELATIVE (FAMILY MEDICAID)

POLICY STATEMENT

Children in certain Family Medicaid Classes of assistance (COAs) must be related to and living in the home with a specified relative.

BASIC CONSIDERATIONS

The following Family Medicaid COAs require that the child(ren) live in the home of a specified relative:

- Low Income Medicaid (LIM)
- Transitional Medical Assistance (TMA)
- Four Months because of Child Support (4MCS)
- Newborn Medicaid (NB)

NOTE: Eligibility for Newborn Medicaid requires that the child live in the home with the mother. Refer to Section 2174, Newborn Medicaid.

The following Family Medicaid COAs do **NOT** require that the child(ren) live in the home with a specified relative:

- Right from the Start Medicaid (RSM) - Child
- Right from the Start Medicaid (RSM) - PgW
- Child Welfare Foster Care Medicaid (CWFC)
- Family Medicaid Medically Needy (FM-MN)
- State Adoption Assistance (SAA)

The following relationships meet the requirements of the specified relative:

- parents (either by birth, legal adoption or step-relationship)
- grandparents (up to great-great-great)
- siblings (whole, half or step)
- aunts/uncles (up to great-great)
- nieces/nephews (up to great-great)
- first cousin
- first cousin once removed (the child of a first cousin)
- spouses of any person named in the above group, even after the marriage is terminated by death or divorce.

EXCEPTION: The spouse of a stepparent or the spouse of a stepsibling is **NOT** within the specified degree of relationship.

BASIC CONSIDERATIONS (cont.)

Relationship is established by one of the following:

- birth
- marriage
- legal adoption
- legal guardianship (except LIM)

An individual who has legal custody of a child does **NOT** meet the relationship requirement.

Adoption or severance of parental rights does **NOT** terminate blood relationship for the specified relative requirement.

The biological parent of a child who has been adopted continues to meet the relationship requirement, but is treated as a non-parent relative.

When a child is adopted, the relatives of the adoptive parent(s) assume the new relationships created by the adoption.

If a child is born or adopted after a marriage is terminated, the former spouse is **NOT** within the degree of relationship **UNLESS** s/he is the biological parent of the child.

PROCEDURES

Trace the relationship of the child to the A/R and document the names and relationships of all direct and/or intermediate relatives.

Accept the A/R's statement of relationship unless information known to the agency conflicts with the A/R's statement or is otherwise questionable.

To establish a child's relationship to a paternal relative, paternity must first be established. Refer to Section 2640 Paternity. Once paternity is established, the A/R's statement of his/her relationship to the child's father may be accepted, unless questionable.

Document the following:

- A/R's statement of relationship and living arrangements
- Source of verification, if questionable.

PROCEDURES (cont.)

If relationship is questionable, document the questionable circumstances and verify relationship with one of the following:

- adoption records
- affidavits of persons present at the birth
- baptismal or other church records
- birth certificate of the child and the relative and any intermediary relative
- census record
- court record
- family Bible
- insurance record
- marriage record
- medical record
- school record
- Social Security record
- vital statistics record
- wills
- other reliable genealogical record.

2250 - COOPERATION WITH CHILD SUPPORT ENFORCEMENT

POLICY STATEMENT

The AU must cooperate with Child Support Enforcement (CSE) in order for AU members to receive Family Medicaid, unless Good Cause exists.

BASIC CONSIDERATIONS

Eligibility of AU members for Family Medicaid is contingent upon cooperation with CSE, unless Good Cause exists.

A non-custodial parent (NCP) whose child receives Medicaid under any Family Medicaid COA is considered to have incurred a debt to the state because of his/her failure to provide medical support for the child.

States are required to establish a program to enforce the NCP's obligation to provide support in the form of medical insurance for his/her child(ren). Child Support Enforcement administers this program in Georgia.

CSE performs the following functions:

- locating the non-custodial parent(s)
- establishing legal paternity
- collecting and distributing child support payments
- obtaining medical support agreements
- participating in hearings regarding Good Cause
- reviewing the agency's Good Cause decisions

A Medicaid AU's rights to medical support are assigned by law to the state upon receipt of Medicaid.

A Family Medicaid AU must cooperate with CSE in locating the NCP of a dependent child included in the AU, establishing legal paternity and obtaining medical support from him/her, unless Good Cause exists.

BASIC CONSIDERATIONS (cont.)

EXCEPTIONS: A referral to, and cooperation with CSE is **NOT** a requirement in the following situations:

- TMA
- Any child-only Family Medicaid case.

  NOTE: A child-only Family Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid under the child's case. An AU that contains a penalized adult is **not** considered a child-only case.
- A child receiving Medicaid under Newborn Medicaid COA.
- Pregnant women receiving Medicaid under any COA are not referred to, and are not required to cooperate with CSE for the unborn child.
- RSM eligible pregnant women are not referred to, and are not required to cooperate with CSE for an existing or unborn child.
- A minor parent who is included in an AU as a dependent child must cooperate with CSE if the minor parent's child is included in the AU unless the minor parent chooses to exclude his/her child.
- A minor parent is not referred to CSE unless he/she is receiving assistance as a dependent child.
- A referral to CSE is not required for an 18 year old receiving Medicaid under RSM-Child and CWFC Medicaid COA's.
- The NCP(s) of a married minor is not legally responsible for the support of a married minor and is therefore not referred to CSE.
- The NCP of a child included in a Medicaid AU is not referred to CSE if the NCP provides health insurance for the child.

BASIC CONSIDERATIONS (cont.)

Cooperation with CSE includes, but is not limited to the following:

- Providing the following relevant information about the NCP in attempt to locate and obtain support from the NCP:
  - name
  - date of birth
  - Social Security number
  - current and/or former address
  - medical insurance information
  - employment information
  - any other information that would assist in locating the NCP.
- Attesting to the above information or attesting to the lack of information, under penalty of law.
- Submitting to a paternity test, if paternity is questionable.

If an AU reapplies for Medicaid following denial or termination due to non-cooperation, the AU must cooperate with CSE prior to approval of the new application.

Good Cause

Good Cause for failure to cooperate with CSE may be claimed for non-cooperation with either the child support process or the medical support process.

Good Cause may be claimed at any time during the application process or following approval.

CSE will not attempt to establish paternity or collect child and/or medical support if Good Cause is established.

When Good Cause is asserted on an active case, CSE will suspend activity until the Good Cause determination is made.

The AU has the primary responsibility for establishing Good Cause. The agency, however, must assist the AU in obtaining information to establish Good Cause upon request of the A/R.

BASIC CONSIDERATIONS

Good Cause (cont.)

Good Cause can be established if one of the following circumstances exists:

- Cooperation with CSE would result in physical or emotional harm to the child or the A/R.
- The child was conceived as the result of rape or incest.
- Legal proceedings for the adoption of the child are pending
- The A/R is receiving assistance from a public or licensed social service agency to resolve the issue of whether to keep the child or release the child for adoption and the discussions have not pended for more than three months.

Assistance is not delayed, denied or terminated pending a determination of Good Cause if the A/R has cooperated in providing information and/or evidence in support of the Good Cause claim.

CHART 2250 .1 – EVIDENCE NEEDED TO SUBSTANTIATE GOOD CASE DETERMINATION

GOOD CAUSE CIRCUMSTANCE	PROOF REQUIRED
Physical and/or emotional harm to the child	Child Protective Services (CPS), court, criminal, law enforcement, medical, psychological or social services records indicating the possibility of physical or emotional harm by the NCP
Physical and/or emotional harm to the grantee relative	Court, criminal, law enforcement, medical psychological or social services records indicating the possibility of physical or emotional harm by the NCP
Child conceived as a result of rape or incest	Medical or law enforcement records indicating conception resulted from rape or incest
Pending legal adoption proceedings	Court documents or statement from social services indicating that adoption is pending
A public or private social service agency is assisting the A/R in deciding whether to keep the child or release him/her for adoption	Written statement from the public or private social service agency assisting the A/R
Any of the above Good Cause circumstances	Sworn statement from individual(s) with knowledge of Good Cause circumstances when the above proof cannot be obtained

BASIC CONSIDERATIONS (cont.)

Failure to Comply

If a Family Medicaid AU member fails to cooperate with CSE without Good Cause, the adult who failed to cooperate is penalized.

EXCEPTIONS:

- In a RSM AU, a parent who fails to cooperate remains in the BG
- Certain Medicaid COAs and circumstances which do not require cooperation with CSE. Refer to exceptions in this Section.

PROCEDURES

Provide the following information to the A/R at initial application, review and when adding a child to the AU:

- explanation of the child support program
- assignment to the state of child support and/or medical support
- the requirement to cooperate with CSE and the consequences for failing to cooperate
- notice to the A/R of the right to claim Good Cause at any time.

Review with the A/R Form 138, Notice of Requirement to Cooperate and Right to Claim good Cause for Refusal to Cooperate in CSE and Third Party Resource Requirements.

Obtain the A/R's signature on Form 138 and provide the A/R with a copy. File the signed original in the case record.

Follow the procedures below when an A/R claims Good Cause:

Determining Good Cause

Step 1

Notify the A/R of the evidence needed to establish Good Cause and establish a deadline for returning the information 20 calendar days from the date Good Cause was claimed.

NOTE: Reasonable extensions may be granted with supervisor approval. Document the reason for the extension.

Step 2

Refer to the Chart 2250.1 in this section for types of documentary evidence needed to establish a Good Cause claim.

PROCEDURES
Determining Good Cause (cont.)

Step 3 Notify CSE immediately when Good Cause is asserted if an NCP had previously been referred.

NOTE: CSE will suspend enforcement activities pending the Good Cause determination.

Step 4 Review all information provided by the A/R and any other available evidence.

Step 5 Request additional evidence from the A/R if necessary. Assist the A/R in obtaining information if requested to do so.

Step 6 Conduct an investigation if the evidence submitted by the A/R is insufficient to substantiate the Good Cause claim. Notify the A/R in writing when such an investigation is required.

NOTE: Do not contact the NCP unless necessary to determine Good Cause. Notify the A/R prior to contacting the NCP.

Step 7 Base the Good Cause determination on the supporting evidence provided by the A/R and/or the information obtained during the investigation.

Step 8 Determine Good Cause within 45 calendar days of the application or 30 calendar days at any other time.

Step 9 Document the Good Cause determination.

Step 10 Notify the A/R of the Good Cause determination.

Good Cause Established If Good Cause **IS** established, notify the A/R that the NCP will **NOT** be referred to CSE and that CSE activities will be terminated if the NCP had been previously referred.

NOTE: Review the case circumstances at the next review if Good Cause is subject to change.

PROCEDURES (cont.)

Good Cause Not Established

If Good Cause is **NOT** established, notify the A/R within 2 days of the decision. Notify the A/R of the following options and allow 10 days for the A/R to choose an option:

- cooperate with CSE
- request a closure of the Medicaid case
- request a hearing
- withdraw the application

Take appropriate action based on the decision of the A/R.

Do not impose a penalty or refer to CSE if a hearing is requested.

Notify the A/R that Good Cause may be asserted again if circumstances change.

Notice of Non-Cooperation

Follow the steps below when a notice received from CSE cites substantial evidence of the AU's non-cooperation.

Step 1 Discuss the non-cooperation allegations with the A/R.

Step 2 Discuss any mitigating circumstances with the CSE agent.

Step 3 Determine if Good Cause exists.

Step 4 If Good Cause is established, notify CSE.

If Good Cause is not established, impose appropriate penalty and notify the AU and CSE. Inform the AU of the right to request a hearing.

Step 5 If a hearing is requested, include the name and address of the local CSE agent on the hearing request.

PROCEDURES (cont.)

Reapplication Following Denial/ Termination Due to Non-Cooperation

Follow the steps below when an application for Family Medicaid is made following denial or termination due to non-cooperation with CSE:

Step 1 Inform the A/R that cooperation with CSE, prior to approval of Medicaid, is required.

Step 2 Obtain A/R signature on the CSE Compliance Agreement. Provide a copy of the Agreement to the A/R and to the CSE office assigned to the case. File the original Agreement in the case record.

Step 3 Inform the A/R that s/he must contact CSE and, if deemed necessary by CSE, schedule an appointment.

Step 4 If CSE notifies the agency that the A/R has cooperated, approve the case if otherwise eligible.

Step 5 If CSE notifies the agency that the A/R has failed to cooperate, determine whether Good Cause for non-cooperation exists. If it is determined that Good Cause exists, approve the case if otherwise eligible.

Step 6 If it is determined that Good Cause for non-cooperation does NOT exist, deny the application and notify the A/R of the decision.

2255 - AGE (FAMILY MEDICAID)

POLICY STATEMENT

A child must be under a specified age to be eligible for Family Medicaid. The age limit depends on the Family Medicaid Class of Assistance (COA) for which eligibility is being considered.

NOTE: Refer to Section 2205, Age, Blind, Disabled Requirement for ABD Medicaid COAs.

BASIC CONSIDERATION

A child must be within the following age limits to be eligible for that Family Medicaid COA.

COA	AGE LIMIT
Child Welfare Foster Care Medicaid	21 years
State Adoption Assistance Medicaid	21 years
PeachCare for Kids	19 years
RSM Child	19 years
Low Income Medicaid	18 years
Work Transition Medicaid	18 years
Transitional Medical Assistance	18 years
Four Months because of Child Support	18 years
Family Medicaid Medically Needy	18 years
Newborn Medicaid	13 months

A child's age affects the financial income limit used in determining eligibility for RSM Child. Refer to Appendix A.2, Family Medicaid Financial Limits and to Section 2182, RSM Child.

There is no age limit associated with RSM Pregnant Woman Medicaid (RSM PgW).

Eligibility for a Medicaid COA ends at the end of the month in which the child reaches the age limit for that COA. A Continuing Medicaid Determination (CMD) must be completed and documented prior to denial or termination of any Medicaid COA.

PROCEDURES

Accept and document the A/R's statement of the child(ren)'s age, unless questionable.

If age is questionable, document the reason age is questioned.

Verify questionable age at the following times:

- at application
- when a child is added to the Family Medicaid AU
- when the agency becomes aware of a discrepancy.

Verify age by one of the following:

- adoption records
- affidavit of persons present at birth
- baptismal or other church records
- birth certificate
- census record
- court record
- driver's license
- family Bible
- insurance record
- medical record
- school record
- Social Security record
- U. S. passport
- vital statistic records
- any other reliable records indicating age or date of birth.

Document the date and source of verification.

If age is questionable and the A/R fails to provide acceptable verification, document the date verification was requested, date verification was due and failure to comply prior to denial or termination of Medicaid.

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2300 - ABD MEDICAID RESOURCES OVERVIEW

POLICY STATEMENT

The value of an A/R's or couple's countable resources cannot exceed the appropriate resource limit in order for the A/R or couple to be eligible for ABD Medicaid.

BASIC CONSIDERATIONS

The appropriate resource limit is dependent upon several factors:

- the A/R's class of assistance (COA)
- whether the A/R is living with or has lived with an ineligible spouse or ineligible parent in LA-A, B, or C
- whether an A/R living in LA-D has a spouse living in LA-A or B

To determine an A/R's appropriate resource limit (individual or couple), refer to Chapter 2500, ABD Financial Responsibility and Budgeting. Refer to Appendix A1 for current individual and couple resource limits for each COA.

Resources are assets such as cash, other personal property and real property that the A/R or ineligible spouse or parent owns under the following conditions:

- The owner has the right, authority, or power to convert the asset to cash (if not already cash).

- The owner is not legally restricted from using the asset for his/her support and maintenance.

An asset is usually income in the month of receipt. Any portion of a countable asset that is retained becomes a resource on the first day of the month following the month of receipt. An asset cannot be considered income and a resource in the same month.

EXCEPTION: Checks dated and received early because the regular date of receipt falls on a weekend or holiday are counted as income, rather than a resource, in the month for which they were intended.

EXCEPTION: Any portion of a lump sum SSI or RSDI payment retained after the month of receipt is excluded as a resource for up to six full calendar months. (These entire lump sum payments are income in the month of receipt.)

The values of some resources are totally or partially excluded. Refer to Section 2304, Treatment of Resources.

BASIC CONSIDERATIONS (cont.)

The countable value of a resource that is applied to the resource limit is the resource's equity value as of the first moment of the first day of each calendar month.

EXCEPTION: Current market value (CMV) is used for automobiles that cannot be totally excluded.

Refer to Section 2303, Determining the Countable Value of Resources.

If an adult A/R lives with a spouse in LA-A or B, the spouse's resources are considered to be available to the A/R.

If a Medicaid child lives with his/her parent(s) in LA-A, B or C, the parent(s) excess resources are deemed to the child. Refer to Section 2502, Deeming.

There are two types of resources.

- Liquid resources are any resources in the form of cash or in any other form that can be converted to cash within 20 workdays.

- Non-liquid resources are any resources which are not in the form of cash and which cannot be converted to cash within 20 workdays.

If an individual is unaware of his/her ownership of an asset, the asset is not a resource during the period for which the individual was unaware of the ownership. The previously unknown asset, including any monies (such as interest) accumulated on it through the month of discovery by the individual, is income only in the month of discovery. Thereafter, the previously unknown asset is subject to resource-counting rules.

2301 – FAMILY MEDICAID RESOURCES OVERVIEW

POLICY STATEMENT

Resources are assets available to the Assistance Unit (AU) that can be converted to cash to meet daily living expenses. These assets must be taken into consideration in determining eligibility.

BASIC CONSIDERATIONS

Resource Limit

Resource limits are set by federal or state law.

The resource limit for the following Family Medicaid Classes of Assistance (COA) is $1000 per AU:

- LIM
- LIM-NH
- CWFC
- SAA

RSM, Newborn Medicaid, TMA, Four Months Child Support Medicaid and PeachCare for Kids have no resource limit.

The Family Medicaid Medically Needy (FM-MN) resource limit increases based on the number of individuals in the Budget Group (BG), as follows:

Number of individuals in FM-MN BG							
1	2	3	4	5	6	7	8
$2000	$4000	$4100	$4200	$4300	$4400	$4500	$4600

The FM-MN resource limit increases by $100 for each additional BG member.

Consideration of Resources

All countable resources available to the AU are applied to the resource limit of the Family Medicaid COA.

If the total countable resources are less than or equal to the resource limit, the AU is eligible based on resources.

If the countable resources exceed the resource limit for a Family Medicaid COA, the AU is ineligible for that COA.

For Family Medicaid COAs, if resources of the BG are within the applicable limit at any time during a month, the AU is resource-eligible for that month.

BASIC CONSIDERATIONS

Consideration of Resources (cont.)

Eligibility based on resources is determined by resolving the following questions:

- Whose resources are considered?
- Who owns the resource?
- Is the resource available to the AU to meet its needs?
- Is the resource countable?
- What is the value of the resource?
- What is the resource limit in the program for which assistance is requested?

Resources are considered liquid or non-liquid and are described as follows:

- Liquid resources are those such as cash or bank accounts which can be converted to cash and are available for daily living expenses.

- Non-liquid resources are those such as property or vehicles which cannot be easily converted to cash.

Resources available to an AU are used to determine eligibility at the following times:

- application
- review
- when the agency becomes aware of a change.

The countable resources of the following individuals are used to determine eligibility:

- eligible AU members
- ineligible aliens
- penalized individuals
- ineligible parents.

NOTE: A portion of the resources of the sponsor of a sponsored alien is used to determine eligibility.

BASIC CONSIDERATIONS (cont.)

Ownership of Resources

It is assumed that a resource belongs to the individual in whose name it is listed unless the AU can prove otherwise.

The burden of proof in establishing that a resource does not belong to an individual rests with the AU.

Convincing evidence such as the following must be provided to rebut ownership:

- statements from other individuals in a position to substantiate the AU member's claim
- legal documents substantiating the claim.

Jointly Owned Resources

A resource that is jointly owned with a non-AU or non-BG member is considered available to the Family Medicaid AU or BG in its entirety if the following conditions apply:

- The AU or BG has the right to dispose of the property.
- The AU or BG can dispose of the property without the consent of the owner.

A resource which is jointly owned with a non-AU or non-BG member is excluded if all of the following apply:

- The resource cannot be practically subdivided.
- Access is dependent on the agreement of the other owner.
- The joint owner states in writing that s/he is unwilling to dispose of the resource.

A portion of a jointly owned resource is included if the AU or BG has access to and may dispose of a portion of the resource.

If a resource is owned by individuals receiving Medicaid in different AUs, the resource is considered available to each owner in equal shares.

BASIC CONSIDERATIONS

Jointly Owned Resources (cont.)

The balance of a jointly owned bank account is divided among the individual owners.

EXCEPTION: In the event an AU or BG member is named on a joint bank account with a non-AU or non-BG individual solely for convenience or emergency, the joint account is excluded as a resource to the AU or BG member if the other individual, or someone in a position to know verifies that s/he has deposited all the monies in the account and all withdrawals are used for the non-AU or non-BG individual's benefit.

Accessibility of Resources

A resource is considered available when the AU or BG has the legal right to liquidate the resource and to use the proceeds.

Resources that are inaccessible to the AU or BG or which AU or BG cannot legally liquidate are excluded.

Examples of excluded resources include the following:

- security deposits on rental property or utilities
- property in probate
- real estate which the AU or BG is making a good faith effort to sell
- resources jointly owned by women and/or children in shelters for victims of domestic violence and their former AU or BG members if access is dependent on the agreement of the joint owner
- money placed in an account for AUs residing in public housing or receiving Section 8 assistance and participating in the Family Self-Sufficiency Program as long as the AU does not have legal access to the money.

NOTE: This list is not all inclusive.

Bankruptcy

Bankruptcy is a condition whereas a debtor, either voluntarily or invoked by a creditor, is judged legally insolvent and the debtor's remaining property is administered and distributed to his/her creditors.

The AU's resources are included or excluded depending on their accessibility and the AU's ability to liquidate the resource and retain the proceeds.

SPECIAL CONSIDERATIONS (cont.)

Countable Resources

Refer to Section 2399, Treatment of Resources by Resource Type.

Excluded income that is retained as a resource the month following the month the income was received is counted as a resource.

Only those resources that are available to the AU at the time that eligibility is determined are counted.

Commingled Resources

Excluded resources may be commingled with countable resources. The excluded resources retain its exclusion for six months from the date the resources were commingled. Beginning in the seventh month following the commingling of funds, the asset's value is counted in its entirety.

Conversion of Resources

In the event an excluded resource is converted to a countable resource, the value of the resource is applied to the appropriate resource limit in the month the resource is converted.

EXCEPTION: Proceeds from the sale of capital goods are considered income. Refer to Section 2499.1, Treatment of Income by Type.

If a countable resource is converted to cash, the value of the cash is countable toward the appropriate resource limit.

Money Received for the Replacement/ Repair of a Resource

Money received from a third party, such as an insurance company that is intended to cover the replacement or repair of a resource is excluded based on the guidelines below:

- The amount that is used for the replacement or repair of the resources is excluded.
- The money must be used or contracted to be used for the repair or replacement of the resource within 6 months of receipt.

Any amount not used for the specific replacement or repair is considered income to the AU. Any unused amount that exceeds the FPL is budgeted as a lump sum in the month received.

BASIC CONSIDERATIONS (cont.)

Determining the Value of a Resource

The most current available information is used to verify the value of a resource in determining eligibility.

Sources which may be used to determine value include the following:

- bank records
- deeds
- property records
- tax records
- appraisals
- tag receipts
- insurance policies
- stock quotes
- statements from individuals in a position to verify the value of a resource.

NOTE: This list is not all inclusive.

Determining Appreciation/ Depreciation

The appreciation or depreciation of a non-liquid resource is considered in determining the value of the resource.

Appreciation is an increase in the value of a resource due to of any of the following:

- improvements to the property
- normal marketing increases
- interest accrued

Appreciation is determined by obtaining verification from a knowledgeable source.

Depreciation is a decrease in the value of a resource due to any of the following:

- normal use of the resource
- destruction of property in a storm, fire or other casualty
- marketing decreases.

Depreciation is determined by obtaining verification from a reliable source.

BASIC CONSIDERATIONS (cont.)

Resource Value

The value of a resource is determined by using one of the following:

- cash value (CV)
- fair market value (FMV)
- equity value (EV)

Cash Value

Cash value is the amount available to the AU if the resource is converted to U.S. funds. In some cases, a penalty may be applied for early withdrawal of funds. The amount of the penalty is deducted from the value of the resource to determine the cash value available to the AU.

Fair Market Value

Fair market value is the amount that the item can sell for on the open market in the geographic area involved.

Equity Value

Equity value is the FMV less legal debts, liens or other encumbrances.

Proof of this legal debt, lien or encumbrance must be in writing and signed by the property owner. It must specify the location of the property and the amount of the debt.

If the owner has financed the purchase of a resource with a loan, the current payoff of the loan must be verified by the lender to determine indebtedness.

Transfer of Resources

A transfer of resources includes selling, swapping, trading, or giving away a countable resource for less than the FMV.

In Family Medicaid Classes of Assistance (COAs), there is no penalty for transferring resources. Only resources owned by the AU at the time of the eligibility determination are considered.

PROCEDURES	
Determining Eligibility on Resources	Follow the steps below to determine whether or not the AU or BG meets the resource limit:
Step 1	Determine whose resources must e considered.
Step 2	Determine if the resource is available to the AU/BG.
Step 3	Determine if the resource must be counted.
Step 4	Calculate the total countable resources.
	If the total countable resources are less than or equal to the resource limit, the AU/BG meets the resource criteria for that COA.
	If the total countable resources exceed the resource limit, deny or terminate benefits.
VERIFICATION	The A/R's statement of the type and value of resources may be accepted, unless questionable. Verification is required when information available to the agency contradicts the A/R's statement or the A/R's statement is otherwise questionable.

2302 - OWNERSHIP OF RESOURCES IN ABD MEDICAID

POLICY STATEMENT	In order for the value of a resource to be applied to the resource limit, the A/R and/or deemor must have an ownership interest in the resource, and the A/R and/or deemor must have the legal right to the use and/or disposal of the resource.
BASIC CONSIDERATIONS	Ownership interests in property, whether real or personal, can occur in various types and forms. Since the type and form of ownership may affect the value of property and even its status as a resource, they are significant in determining resource eligibility.

PROCEDURES

Use the following chart to determine the value of an A/R or deemor's ownership interest in a resource.

Chart 2302.1 - Determining the Ownership of a Resource

Resource	Ownership Interest	Value
Real Property	Fee Simple	Count the entire equity value to the A/R or deemor.
Real Property	Tenancy-In-Common	Determine and count the A/R's or deemor's share of the equity value (each owner does not necessarily own equal shares).
Real Property	Joint Tenancy or Tenancy by the Entirety	Divide the equity value by the number of joint owners (each owner owns an equal share).
Real Property	Life Estate	Non-FBR A/R: Exclude total value. FBR A/R: Use Chart 2322.1 - Unisex Life Estate or Remainder Interest Table to determine value. Refer to Section 2322, Life Estate and Remainder Interests.
Real Property	Remainder Interest	Divide the value of the remainder interest by the number of persons with a remainder interest. Refer to Section 2322, Life Estate and Remainder Interests.
Unprobated Estate	Heir Interest	Will: Count the value of any resources left to the A/R or deemor until probated. No Will: Use Georgia's Intestate Laws to determine the A/R's or deemor's share. Refer to Section 2320, Inheritances and Unprobated Estates.

Chart 2302.1 - Determining the Ownership of a Resource		
Resource	**Ownership Interest**	**Value**
Financial Instrument (savings or checking account, etc.)	Joint	Consider the financial instrument to be owned in equal shares by the Medicaid A/Rs whose names are listed as owners of the instrument. Do not allow a share of the financial instrument to a Non-Medicaid owner. If the A/R rebuts ownership of or unrestricted access to the financial instrument, refer to Section 2334, Savings and Checking Accounts, for rebuttal procedures.

NOTE: Any ownership interest in homeplace property is excluded.

2303 - DETERMINING THE COUNTABLE VALUE OF RESOURCES FOR ABD MEDICAID

POLICY STATEMENT

The countable value of a resource is its equity value as of the first moment of the first day of the month of verification.

BASIC CONSIDERATIONS

To determine the value of a specific resource, refer to the specific section in this chapter on the particular resource.

The countable value of a non-liquid resource is its equity value.

Equity Value

Equity value (EV) is the current market value (CMV) less the following encumbrances:

- the amount of principal owed
- any prepayment penalty
- any other debts (liens, loans, etc.).

Current Market Value

The current market value (CMV) of a resource is the going price for which it can reasonably be expected to sell on the open market in the particular geographic area involved.

For real property located in Georgia, the CMV is the *assessed tax value* multiplied by 2.5 unless an A/R successfully rebuts this value.

First Day of Month Rule

If the total countable value of an A/R's resources, as of the first moment of the first day of the month, exceeds the resource limit, the A/R is ***ineligible*** based on resources for the entire month, regardless of fluctuations during the month.

If the total countable value of an A/R's resources, as of the first moment of the first day of the month, does ***not*** exceed the resource limit, the A/R is eligible for the entire month, regardless of fluctuations during the month.

PROCEDURES

Use the following chart to determine whether the A/R is eligible for ABD Medicaid based on the countable value of his/her resources.

Chart 2303.1 - Determining Eligibility Based on Countable Resources	
IF the countable value of resources	**THEN based on resources**
does not exceed the resource limit on the first moment of the first day. of the month	the A/R is eligible for the month.
exceeds the resource limit on the first moment of the first day of the month	the A/R is ineligible for the month.
does not exceed the resource limit on the first moment of the first day of the month BUT increases in value until it exceeds the resource later in the month	the A/R is eligible for the month AND DFCS must redetermine the value of resources as of the first moment of the first day of the following month.
exceeds the resource limit on the first moment of the first day of the month BUT decreases in value until it does not exceed the resource limit later in the month	the A/R is ineligible for the month AND DFCS must redetermine the value of resources as of the first moment of the first day of the following month.

PROCEDURES

(cont.)

Resource Eligibility at Application

For applications, verify the countable value of each resource as of the first moment of the first day of the month of application and as of the first moment of the first day of ***each*** prior month for which eligibility is being determined.

Resource Eligibility at a Review

At each review, verify the value of ***all*** resources as of the first moment of the first day of the same month.

Rebuttal of CMV of Real Property

If an A/R rebuts the Tax Digest CMV, require the A/R to obtain two estimates from knowledgeable sources, such as a realtor. Use the ***average*** of the two estimates as the CMV.

2304 - TREATMENT OF RESOURCES FOR ABD MEDICAID

POLICY STATEMENT

The treatment of resources is dependent upon several variables.

BASIC CONSIDERATIONS

Non-FBR COAs vs. FBR COAs

The following resources are treated differently for non-FBR and FBR A/Rs:

- automobiles
- burial contracts and burial space items
- cemetery lots (refer to Section 2311, Burial Contracts/Burial Space Items)
- funds set aside for burial
- life insurance policies
- accrued dividends earned on life insurance policies
- life estate interests
- income producing property
- household goods and personal effects
- promissory notes/loans/mortgages

NOTE: The above resources may be excluded under Non-FBR policy (refer to the Resource Chart in Section 2399). The exclusion only applies **IF** the resources are owned by the A/R, or transferred by the A/R to a spouse or into a trust. **IF** a resource excluded under Non-FBR policy is transferred to someone or something other than a spouse or a trust, a transfer of resource penalty should be developed. Refer to Section 2342, Transfer of Resources.

All other resources are treated the same for all classes of assistance.

EXCEPTION: Refer to Absence from Homeplace in Section 2316, Homeplace: ABD Medicaid.

Special Exclusions

Certain non-liquid resources that would normally be counted may be totally or partially excluded if specific conditions are met.

Income Producing Property

Personal or real property which *currently* (or is expected to resume) produces earned income, unearned income, goods, or services, may be partially or totally excluded. Refer to Section 2327, Property Essential to Self-Support.

BASIC CONSIDERATIONS (cont.)

Undue Hardship Provision

Undue hardship is defined as a situation wherein an individual would be deprived of medical care such that his/her health or life would be endangered; or would be deprived of food, clothing, shelter, or other necessities of life. Undue hardship does not exist if the individual is merely inconvenienced or restricted in lifestyle.

There are three conditions for use of the undue hardship provision, only one of which needs to be met:

- An institutionalized spouse who (or whose spouse) has excess resources will not be found ineligible for Medicaid where it is determined that denial of eligibility on the basis of having excess resources would create undue hardship.

- An individual for whom receipt of distribution from a Medicaid qualifying trust would cause ineligibility will not be found ineligible for Medicaid where it is determined that such denial would create undue hardship.

- An individual having transferred resources for less than the fair market value, or having transferred resources into a trust, will not be found ineligible for Medicaid nursing facility services or home and community based services where it is determined that such denial would create undue hardship.

Undue hardship must be considered by the worker in each of the above situations; the A/R does not have to request it. For transfer of resource penalties, the notice concerning the penalty must contain a statement that undue hardship was considered and determined not to be applicable. See Section 2342, Transfer of Resources.

PROCEDURES

Bona Fide Effort to Sell

Exclude personal or real property for any month in which the A/R is making a bona fide effort to sell the property.

Evidence of a *bona fide effort* to sell includes any of the following:

- listing the property with a realtor
- a *for sale* sign on the property
- advertisement in a newspaper
- has not refused a reasonable offer (2/3 of CMV).

PROCEDURES (cont.)

Bona Fide Effort to Sale (cont.)

If the real property for which a bona fide effort to sell is being made is non-homeplace, require the A/R to sign a statement that s/he has tried to sell, is trying to sell, or will try to sell the property within the next 30 days. Require the A/R to market the resource at current market value (CMV).

Verify/document that the A/R has not refused a reasonable offer on the property (2/3 of the CMV).

Verify/Document the A/R's past and continuous efforts to sell the property at the following intervals:

- prior to approval of the application
- 9 months after approval
- every three months thereafter.

NOTE: The A/R has 30 days to put the property on the market after signing a statement of intent to do so.

Undue Hardship to Co-Owner

Exclude jointly owned real property if the sale would cause undue hardship to the co-owner.

Consider that sale of the property would cause undue hardship to a co-owner if one of the following situation exists:

- The co-owner uses the property as his/her principal place of residence.
- The co-owner would have to move if the property were sold.
- The co-owner has no other readily available housing.

If the A/R alleges that the sale of certain real property would force a co-owner living on it to move, obtain the following documentation and verification:

- The individual's signed statement to that effect
- Evidence of joint ownership

Obtain a statement from the co-owner regarding whether he or she:

- Uses the property as his or her principal place of residence
- Would have to move if the property were sold
- Have other living quarters readily available.

PROCEDURES (cont.)

Undue Hardship to Co-owner (cont.)

Accept any reasonable allegation from the co-owner that there is no readily available housing, no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual.

Restricted Allotted Indian Lands

Consider restricted allocated land owned by an individual who is of Indian descent from a federally recognized Indian tribe to be an excluded resource if the individual cannot sell, transfer or otherwise dispose of it without permission from other individuals, his or her tribe, or an agency of the Federal Government.

If an individual alleges owning land that meets the criteria above, complete the following procedures:

- obtain a copy of any document or documents that might identify it as such
- verify the allegation with the appropriate Indian agency.
- Document appropriately.

Undue Hardship Provision

Consider the undue hardship provision on every case, and apply the provision on a case by case basis. Determine the value of countable resources. Make a decision based on the facts present in the case. If a determination is made that the provision does not apply, the notice of the penalty to the A/R must include a statement that undue hardship was considered and determined not to be applicable.

Thoroughly and completely document the case record to support applying the undue hardship provision.

- document which of the three conditions is met.
- document how the condition is met including why the individual will suffer irrevocable harm if denied Medicaid.

2305 - COMMINGLED FUNDS

POLICY STATEMENT	Excluded liquid resources may be commingled in various financial instruments, such as a checking account, only if they are clearly identifiable. FBR A/Rs cannot commingle burial funds.
BASIC CONSIDERATIONS	Identifiability does not require that excluded funds be kept physically apart from other funds, such as in a separate bank account. Burial funds owned by non-FBR A/Rs can be commingled with other funds.
PROCEDURES	When withdrawals are made from an account with commingled funds, always assume that non-excluded funds are withdrawn first, leaving as much of the excluded funds in the account as possible. If excluded funds are withdrawn, the excluded funds left in the account can be added to only in one of the following ways: • deposits of subsequently received funds that are excluded under the same provision • excluded interest. Interest earned by funds excluded under this provision may or may not be excluded from resources and income. Refer to Section 2399, Treatment of Income Retained After the Month of Receipt, and Interest in Chart 2399.2, Treatment of Income in ABD Medicaid, for resource and income treatment of interest earned on commingled funds.

2306 - AGENT ORANGE

POLICY STATEMENT	Permanently exclude from resources unspent portions of Agent Orange Payments.
BASIC CONSIDERATIONS	Agent Orange payments are made to Vietnam veterans exposed to Agent Orange defoliant. Payments may be made to surviving spouses. Interest earned on unspent portions is a countable resource if left to accrue.
PROCEDURES	Verify the date(s) and amount(s) of payments. If deposited, obtain a copy as to the date(s) and amount(s) of deposits, if available. If not available, obtain a written statement from the A/R or RP. Refer to Section 2305, Commingled Funds.

2307 - AUSTRIAN SOCIAL INSURANCE PAYMENTS

POLICY STATEMENT	Permanently exclude from resources unspent Austrian Social Insurance Payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.
BASIC CONSIDERATIONS	Austrian Social Insurance Payments not based on wage credits granted under Paragraphs 500-506 are not excluded from resources under this provision. Interest earned on unspent portions is not excluded from income or resources.
PROCEDURES	If the payments were excluded from income on the basis of wage credits, exclude unspent portions as a resource indefinitely. If the payments are not based on wage credits, obtain a signed statement from the individual as to the date(s) and amount(s) of any deposits corresponding to the Austrian Social Insurance Payments.

2308 -VEHICLES

POLICY STATEMENT

The treatment of a vehicle as a resource is dependent upon the Class of Assistance (COA) under which eligibility is determined.

BASIC CONSIDERATIONS

A vehicle, operable or temporarily inoperable, which is used for transportation and includes automobiles, trucks, motorcycles, golf carts, animal-drawn vehicles and animals.

Permanently inoperable (junked) vehicles and vehicles used solely for recreational purposes are considered personal property. The equity value of each is a countable resource.

Ownership of a vehicle must be established before it can be considered a resource. Refer to Section 2301, Family Medicaid Resource Overview and Section 2302, Ownership of Resources in ABD Medicaid, for policy regarding jointly owned resources.

A vehicle which is used by a member of the assistance unit (AU) or budget group (BG) but which is registered to and owned by another individual who is not a member of the AU or BG is not considered a countable resource.

Leased vehicles are not considered when determining eligibility, as the AU/BG does not *own* the vehicle.

The value of a vehicle may not be considered when determining eligibility for certain COAs.

ABD Medicaid Non-FBR COAs

Exclude all vehicles, except for those considered personal property, regardless of the number owned, use(s) of the vehicles or value(s) of the vehicles.

ABD Medicaid FBR COAs

Exclude the value of one vehicle if used by the applicant/recipient (A/R) for any of the following reasons:

- necessary for employment
- necessary for the treatment of an acute or chronic medical condition
- modified for operation by, or the transportation of a handicapped person
- necessary because of climate, terrain, distance or similar factors for the performance of normal daily activities.

Up to $4500 of the fair market value (FMV) of one vehicle may be excluded if the automobile cannot be totally excluded for any of the above reasons. The value in excess of $4500 is a countable resource.

BASIC CONSIDERATIONS

ABD Medicaid FBR COAs (cont.)

The equity value (EV) of any vehicle other than those wholly or partially excluded is a countable resource.

Exclusions are applied in the manner most advantageous to the A/R.

Family Medicaid COAs

The value of a vehicle is excluded if used for either of the following reasons:

- primarily as a dwelling
- over 50% of the time for income-producing purposes.

The value of all other vehicles must be considered when determining the total countable resources for the AU.

A $4,650 exclusion of one vehicle's value is given, regardless of the use of the vehicle.

The AU is allowed to choose the vehicle to which the exclusion is applied. Exclusions are applied in the manner most advantageous to the AU.

The Fair Market Value (FMV) of a vehicle is any one of the following:

- the assessed tax value determined by the county tag office, multiplied by 2.5
- the average trade-in value from the most current available NADA Official Used Car Guide
- the statement of a dealer.

If the AU claims the FMV is not representative of the value of the vehicle, the AU must be given the opportunity to provide a value rebuttal from another reliable source.

The Equity Value (EV) is the FMV less any indebtedness of financial encumbrances.

Special equipment to adapt a vehicle for use by a handicapped person is not considered in determining the value of a vehicle.

PROCEDURES

ABD Medicaid Non-FBR COAs

Document the A/R's statement as to the number and make of each vehicle owned. Exclude the value of all vehicles except for those considered personal property.

ABD Medicaid FBR COAs

Verify and document the FBR A/R's ownership of each vehicle. For each vehicle owned, include a photocopy of one of the following in the case record:

- title
- current year registration
- bill of sale

Verify and document usage of each vehicle. Accept the A/R's statement as verification of the use of a vehicle unless questionable. Determine the reason if a vehicle is owned but not used for transportation.

Unless questionable, accept the A/R's statement regarding factors qualifying a vehicle for an exclusion, regardless of the value of the vehicle.

Verify and document the FMV of a vehicle from one of the following sources:

- For vehicles up to 8 years old, the FMV is the average trade-in value listed in the most current available NADA Official Used Car Guide.
- For vehicles 8 to 18 years old, the FMV is the average trade-in value listed in the most current available NADA Older Car Guide.
- For vehicles more than 18 years old, use the value listed for the vehicle at 18 years old.

If the A/R disagrees with the NADA listed value and eligibility is affected by the value, give him/her the opportunity to rebut the value.

Rebuttal evidence consists of a written appraisal of the vehicle's CMV obtained by the A/R at his/her own cost from a disinterested knowledgeable source such as a used car or truck dealer or automobile insurance company.

PROCEDURES

ABD Medicaid FBR COAs (cont.)

Provide the rebuttal source with a complete description of the vehicle including year, make, model, equipment, etc. Assume the vehicle to be in average condition unless there is evidence to the contrary.

Inform the rebuttal source that the estimate should show the average retail value for the vehicle in the geographic area covered by the local media. If the estimate is obtained by telephone, document the file with all the pertinent facts.

Family Medicaid COAs

The AU's statement of ownership of a vehicle is accepted, unless questionable.

Follow the steps below to determine the countable resource value of a vehicle for Family Medicaid:

Step 1 Determine what vehicle(s) are owned by the AU and the use of each.

Step 2 Determine if the value of any vehicle(s) can be totally excluded based on use.

Step 3 Determine the year, make, model and FMV of any remaining vehicle(s) owned by the AU.

Step 4 Determine the EV by subtracting the amount owned from the FMV.

Step 5 Apply the $4,650 exclusion to one vehicle.

Step 6 Total the countable value of all vehicles, add to the value of other countable resources and apply to the resource limit.

2309 - BONDS-MUNICIPAL, CORPORATE, GOVERNMENT

POLICY STATEMENT	The value of a bond as a resource is its Current Market Value (CMV) as of the first moment of the first day of the month of verification.
BASIC CONSIDERATIONS	A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.
Municipal	A municipal bond is the obligation of a state or a locality. Localities include a county, city, town, village, or special purpose authority, such as a school district.
Corporate	A corporate bond is the obligation of a private corporation.
Government	A government bond, as distinct from a U.S. Savings Bond, is a transferable obligation issued or backed by the Federal government. Refer to Section 2310, Bonds - U.S. Savings.
PROCEDURES	Verify the CMV by contacting the seller of the bond or a securities company, such as a stockbroker.

2310 –BONDS - U. S. SAVINGS

POLICY STATEMENT	The resource value of a U. S. Savings Bond is its current market value (CMV).
BASIC CONSIDERATIONS	U. S. Savings Bonds are obligations of the federal government. Unlike other bonds, they are not transferable. They can only be sold back to the federal government. If bonds are owned jointly, co-owners own equal shares of the value of the bond. A U. S. Savings Bond is not a resource to a co-owner if another co-owner has and will not relinquish possession of it.
PROCEDURES	If it is available, use the Table of Redemption Values for U. S. Savings Bonds to determine value. If the table is not available, obtain the value by telephone or in writing from a local bank. The bank will need the series, denomination, and date of purchase and/or issue date. Document the case. If the individual alleges that he or she cannot submit a bond because a co-owner has and will not relinquish physical possession of it, obtain a signed statement from the co-owner.
ABD Medicaid	Determine the CMV as of the first moment of the first day of the month
Family Medicaid	Accept the A/R's statement of CMV unless questionable.

2311 - BURIAL CONTRACTS (PRE-PAID OR PRE-NEED) AND BURIAL SPACE ITEMS

POLICY STATEMENT

The treatment of burial contracts and burial space items is dependent upon whether an A/R's class of assistance (COA) is FBR, Non-FBR or Family Medicaid.

BASIC CONSIDERATIONS

Contracts

A prepaid (or pre-need) burial contract is an agreement whereby a buyer pays in advance for a burial that the seller agrees to furnish upon death of the buyer or other designated individual.

Irrevocable contracts are not resources. All burial contracts purchased in Georgia are revocable. Assume that all other contracts are revocable unless the A/R provides proof to the contrary.

A non-itemized contract does not indicate the cost of each item.

Only one burial contract designated on a particular individual may be considered for exclusion from resources.

NOTE: For Non-FBR ABD Medicaid COAs, a life insurance policy that is purchased to fund a prepaid burial contract has no resource value regardless of the face value or owner of the policy. The face value should be equal to the purchase price of the burial contract.

Burial Space Items

Burial space items may be part of a burial contract or owned outright. The following are burial space items:

- burial plot
- grave site
- crypt
- mausoleum
- casket
- urn
- niche
- other repository customarily and traditionally used for the deceased's bodily remains.

BASIC CONSIDERATIONS

Burial Space Items (cont.)

The term burial space item also includes necessary and reasonable improvement for additions to such spaces, including but not limited to the following:

- vaults
- headstones, markers or plaques
- other burial containers for caskets
- arrangements for the opening and closing of the gravesite
- contracts for the care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care.

Immediate Family

Immediate family includes the Medicaid individual's spouse; minor and adult natural, adopted and step children and their spouses; natural and adoptive parents and their spouses, siblings and their spouses. Immediate family does not include members of an ineligible spouse's family unless they are also within the appropriate degree of relationships to the Medicaid individual.

PROCEDURES

Family Medicaid

Exclude up to $1500 of the combined equity value (EV) of all burial contracts and one burial plot per each AU or BG member. Count the EV of any additional plot(s) toward the resource limit.

Burial Contracts Non-FBR Medicaid COAs

Exclude from resources the entire refund value of any prepaid burial contract owned by a Non-FBR A/R or deemor that is designated for the A/R, spouse or deemor.

Count as a resource the entire refund value of a non-itemized revocable burial contract owned by a Non-FBR A/R or deemor that is designated for someone other than the A/R, spouse or deemor.

Exclude from resources the current refund value of burial space items included in an itemized, paid in full burial contract owned by a Non-FBR A/R or deemor that is designated for an immediate family member other than the A/R, spouse or deemor.

Count as a resource the current refund value of non-burial space items included in an itemized, paid in full burial contract owned by a Non-FBR A/R or deemor that is designated for an immediate family member other than the A/R, spouse or deemor.

Count as a resource the entire refund value of a burial contract owned by a Non-FBR A/R or deemor that is designated for someone other than an immediate family member.

PROCEDURES (cont.)

Burial Contracts FBR Medicaid COAs

Count as a resource the entire refund value of a *non-itemized,* revocable burial contract owned by an FBR A/R or deemor.

Exclude the refund value of all burial space items included in an itemized, revocable burial contract that is paid in full if the contract is owned by the FBR A/R or deemor and designated for an FBR A/R, his/her spouse or immediate family member.

Count as a resource the refund value of all non-burial space items included in an itemized, revocable burial contract that is *paid in full* if the contract is owned by the FBR A/R or deemor.

Count as a resource the entire refund value of a burial contract owned by a Non-FBR A/R or deemor that is designated for someone other than an immediate family member.

Burial Contracts Designated as Burial Funds

Allow the A/R to designate a non-excluded burial contract or the non-excluded portion of a burial contract as a burial fund.

If a burial contract is not paid in full, allow the A/R to designate the burial space items included in the contract only as a burial fund unless the contract or funeral home verifies that full payment has been satisfied on a particular burial space item, and the item is available for use before the contract has been paid in full.

Significant Hardship

Consult the supervisor for instructions if the A/R claims that selling or cashing in a burial contract will cause significant hardship.

Documenting Burial Contracts

Obtain a copy of each excluded burial contract to verify the following:

- for whom the contract is designated
- that the contract is with a business that conducts funeral services.

Obtain a copy of each original *non-excluded* burial contract and obtain a statement from the provider as to the current refund value of the contract.

PROCEDURES (cont.)

Documenting Burial Contracts

Obtain a statement from the provider as to the amount the A/R has paid on the burial contract if the contract is not paid in full. This is the current countable resource value unless the contract is designated as a burial fund.

Contact the provider and verify the refund value of the contract. If the contract is paid in full but obviously does not include the cost of burial space items, count the refund value as a resource.

Contact the provider and verify the current refund value of the contract if it is paid in full and includes the cost of burial space items.

Determining the Current Resource Value of the Non-Burial Space Items Included in a Burial Contract

Follow the steps below to determine the current resource value of the non-burial space items portion of a burial contract:

Step 1 Determine the current refund value of the contract.

Step 2 Determine the dollar amount of the original contract that represents the value of non-burial space items.

Step 3 Divide the dollar amount from Step 2 by the total dollar amount paid for the original contract. Carry to three decimal points.

Step 4 Multiply the quotient from Step 3, which is the percentage of the contract that represent non-burial space items, by the current refund value of the contract from Step 1.

Step 5 Count the result of Step 4 as the current resources value of the contract.

NOTE: This percentage determined by Step 3 may be used at each review to determine the current resource value of the contract.

Resource Treatment of Interest Earned on Burial Contracts

Exclude from resources any interest left to accrue on the excluded portion of a burial contract.

Count as a resource any interest left to accrue on the non-excluded portion of a burial contract.

PROCEDURES (cont.)

Burial Plots FBR COAs and Non-FBR Medicaid COAs

Exclude from resources all burial plots (cemetery plots) owned outright by a Non-FBR A/R or deemor.

Document the A/R's statement as to the number of burial plots owned.

Burial Space Items Non-FBR and FBR Medicaid COAs

Exclude burial space items owned by an A/R or deemor from resources only if they are designated for the A/R, the A/R's spouse or any other member of the A/R's immediate family.

Count burial space items owned by an A/R or deemor as resources if they are designated for anyone other than a member of the A/R's immediate family or they are not designated for use by a specific individual.

Allow the burial space items exclusion in addition to, and not as part of, the burial funds exclusion.

Exclude only one per person of burial space items that serve the same purpose, such as a casket or an urn.

Documentation and Verification of Burial Space Items

Accept the A/R's statement as to the number of burial space items the A/R and/or deemor own. Document the statement in the case record.

If an A/R alleges owning only one of a particular burial space item, or an A/R and spouse allege owning no more than two, assume that the items are designated for the A/R and spouse. Document the allegation in the case record.

If an A/R or A/R and spouse allege owning more than one (or two for the A/R and spouse) of a particular burial space item, obtain a signed statement (Form 987) showing the name and relationship of the person for whose burial each item is designated.

Verify the CMV and EV of all non-excluded burial space items using Form 986. Document the case and system appropriately.

2312 - BURIAL FUNDS

POLICY STATEMENT

For ABD Medicaid an A/R or deemor may designate non-excluded resources as funds set aside for burial for the A/R and/or the A/R's spouse.

There is no burial fund exclusion in Family Medicaid.

BASIC CONSIDERATIONS

To designate funds for burial the A/R must sign a statement (Form 985) that includes the following:

- the value and owner of the resource
- for whose burial the resource is set aside
- the form(s) in which the resource is held (burial contract, bank account, etc.)
- the date the individual first considered the funds set aside for the burial of the person specified.

EXCEPTION: For QMB, SLMB, QI-1 AND Q1-2 applications, accept the A/R's statement regarding designation of burial funds.

If an A/R uses excluded burial funds for a purpose other than the burial arrangements of the A/R or the A/R's spouse for whom the funds were set aside, the amount used will be considered as income in the month following the expiration of timely notice. However, this penalty applies only if the A/R's resources would have exceeded the resource limit for the month in which the excluded funds were used had the exclusion not been given.

Any appreciation in the value of excluded burial funds is excluded from resources and income. Funds may be considered designated prior to eligibility and any appreciation of the funds after the date of designation may be excluded.

Any appreciation in the value on the non-excluded portion of designated burial funds is a resource if retained beyond the month the interest is payable (first available). Refer to Chart 2399.1, Treatment of Income in ABD Medicaid, for information on the income treatment of interest earned on burial funds.

Additional amounts can be added to the original designation until the maximum exclusion has been designated. Accumulated interest earned on the original exclusion is not included in determining if the maximum exclusion has been reached.

BASIC CONSIDERATIONS (cont.)

Whether an A/R's class of assistance (COA) is non-FBR or FBR will determine the following:

- the types of resources which may be designated
- the amounts which may be excluded
- whether or not the burial funds may be commingled with non-burial funds.

Non-FBR COAs

Non-FBR A/Rs may designate ANY non-excluded resource, liquid or non-liquid.

The maximum burial funds exclusion is $5000 for the A/R and $5000 for the A/R's ineligible spouse. Any amount may be designated.

Burial funds may be commingled with non-burial funds if they are separately identifiable.

Burial funds may be designated retroactively to 4/1/88 if they are separately identifiable and can be tracked. For purposes of identification, consider burial funds to be first in and last out in commingled accounts.

For future reviews, when funds are commingled, determine the ratio of the non-excluded portion of the fund to the excluded portion by dividing the value of the non-excluded portion by the total amount designated. Carry the quotient to 3 decimals.

NOTE: The decimal is also used to project interest income earned on the non-excluded portion.

Verify the current value of the designated resource.

Determine what portion of the current value is a countable resource by multiplying the above decimal by the current total value.

NOTE: The same ratio (decimal) may be used every year as long as there are no deposits or withdrawals from the total designated fund. Otherwise a new ratio calculation is required.

BASIC CONSIDERATIONS (cont.)

FBR COAs

FBR A/Rs may designate non-excluded, **liquid** resources only as burial funds. Non-liquid resources cannot be designated for burial.

Types of designated funds may include the following:

- financial accounts, such as savings, checking accounts, CDs, stocks, bonds, etc.
- the CSV of non-excluded life insurance policies
- amounts paid toward installment burial contracts
- non-excluded portions of revocable burial contracts
- cash.

Designated burial funds **CANNOT** be commingled with non-burial funds.

If the A/R wishes to designate a portion of a liquid resource, the A/R must put the designated portion into a separate account/instrument. The exclusion becomes effective the month after the separation of funds.

An A/R may designate retroactively to 4/1/88 as long as no withdrawals were made from the funds for reasons other than burial expenses.

Once the date that burial funds were considered as set aside for burial has been established, the exclusion may be applied the following month, provided the following month is no earlier than the first month of Medicaid eligibility.

Consider the current cash value as of the first day of the month for which the fund is excluded as a burial fund to be the principal amount of the burial fund.

The maximum burial fund exclusion for FBR A/Rs is $1500 for the A/R and $1500 for the A/R's ineligible spouse. Any amount may be designated.

PROCEDURES

Non-FBR COAs

Apply the $5000 limit to any resource(s) the Non-FBR designates as burial funds. Consider the remainder to be a countable resource(s).

FBR COAs

Reduce the $1500 burial funds exclusion by the value of any of the following assets owned by the A/R and deemor:

- the face value of burial insurance policies
- the face value of any life insurance policy on the A/R or A/R's spouse if the CSV was excluded because the total FV of all policies held on each person did not exceed $1500
- the non-burial space portions of irrevocable burial trusts or contracts.

Use the amount of $1500 remaining after all the above are subtracted as the amount of burial funds the individual (A/R or deemor) is allowed to exclude.

Determining the Resource Value of Burial Funds at Application and Review

At the time of the initial designation, determine the ratio of the non-excluded portion of a designated burial resource by dividing the value of the non-excluded portion by the total amount of the designated resource. Carry the quotient to three decimals. Use this figure to determine the non-excluded, countable resources value of the designated burial resource at future reviews.

At each review, verify the current value of the total designated resource and multiply it by the non-excluded percentage of the designated resource to determine the current resource value of the non-excluded portion.

2313 – CONTRACTS - PROMISSORY NOTES, LOANS, AND PROPERTY AGREEMENTS

POLICY STATEMENT	The resource value of a promissory note, loan or property agreement is determined by whether an A/R's class of assistance (COA) is Non-FBR or FBR ABD Medicaid. This is not applicable in Family Medicaid COAs.
BASIC CONSIDERATIONS	The context of the instructions in this section assumes that the individual is the creditor (lender of money or seller of property) and therefore the owner of the promissory note, loan or property agreement. A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered. A loan is a transaction whereby one party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under state law. A written loan agreement is a form of promissory note. A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, etc. Personal property agreements such as a pledge of crops, fixtures, inventory, etc, are commonly known as chattel mortgages.
PROCEDURES	
Non-FBR Medicaid COA s	Totally exclude a promissory note, loan or property agreement owned by a non-FBR A/R or deemor from resources if the A/R or deemor is receiving regularly scheduled payments from the borrower. The payment must include repayment of the principal. The document should specify that repayment of the principal is expected. Count as unearned income the entire amount of any payment from a contract owned by a Non-FBR A/R or deemor.

PROCEDURES

Non-FBR Medicaid COAs (cont.)

If the borrower is not making scheduled payments on the contract, or the payments do not include repayment of the principal, follow the procedures for determining the resource value of a contract owned by a FBR A/R.

FBR COAs

Assume that the resource value of a promissory note, loan or property agreement owned by a FBR A/R or deemor is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less value or no CMV at all.

Verification and Documentation

Non-FBR Medicaid COAs

Obtain a copy of the contract, if written. Obtain written statements from the A/R and borrower that include the amount of the payments and the payment schedule.

FBR Medicaid COAs

Obtain a copy of the agreement for the file. Cease development if including the original balance in countable resources does not cause ineligibility.

If including the outstanding principal balance as a countable resource causes ineligibility, inform the individual that the outstanding principal balance will be used in determining the resource value unless s/he submits either of the following within 30 days:

- evidence of a legal bar to the sale of the agreement
- statements from two knowledgeable sources that buy notes, one of which may be chosen by DFCS, as to the value of the note, including the following information:

    - Do you buy notes?
    - Would you be willing to buy this note?
    - If yes, how much would you pay for this note?
    - If not, why not?

Look under Mortgages in the telephone yellow pages for knowledgeable sources. Knowledgeable sources include anyone regularly engaged in the business of making such evaluations, such as banks or other financial institutions, private investors or real estate brokers. The estimate must show the name, title, and address of the source.

PROCEDURES

Verification and Documentation (cont.)

FBR COAs (cont.)

If both brokers offer to buy the note, count the higher offer as a resource. If only one broker offers to buy the note, count that amount as a resource. If neither broker offers to buy the note, the note is excluded as a resource.

If the note is counted as a resource, count the interest portion of payments as income.

If the note is excluded as a resource, count the entire amount of all payments as income.

Oral Loans

For oral loan agreements, obtain a statement from each of the parties involved (lender and borrower) acknowledging the borrower's obligation to repay and specifying the following information:

- the date and amount of the original loan
- any collateral used
- the schedule and amount of payments if any, or other plan for repayment (e.g., borrower plans to repay the loan when he or she receives expected income)
- the outstanding principal balance.

If both the lender and borrower agree that an oral loan exists, consider the oral loan to be a contract. If otherwise, the oral loan agreement is not a contract, and therefore not a resource to the lender.

2314 - DISASTER ASSISTANCE

POLICY STATEMENT	Unspent portions of Federal Disaster Assistance are permanently excluded as a resource.
BASIC CONSIDERATIONS	To be excluded as a resource, Disaster Assistance must have met requirements for excluding it as income. Interest earned on unspent Disaster Assistance is excluded as income and resources.
PROCEDURES	Verify that unspent Disaster Assistance was excluded as income. Verify the dates and amounts of payments. If payments were deposited into a financial account, obtain a copy of the account statement(s) to determine the dates and amounts of deposits. Refer to Section 2305, Commingled Funds, for information on how to treat Disaster Assistance payments commingled in a financial account with other non-excluded resources.

2315 - DIVIDENDS, ACCRUED

POLICY STATEMENT	Accrued dividends earned on financial investments, such as stocks, are countable resources separate and apart from the investment resource. This applies to all ABD Medicaid classes of assistance (COA). They are excluded in Family Medicaid COAs. Whether or not accrued dividends on life insurance policies are countable resources is dependent upon whether the A/R 's COA is Non-FBR or FBR.
BASIC CONSIDERATIONS	A dividend is a share of surplus company earnings paid on some financial investments and life insurance policies. Accrued dividends are dividends that an A/R has constructively received but left in the custody of the company.
Non-FBR COAs	For Non-FBR COA, dividends left to accrue on all life insurance policies are excluded.
FBR COAs	For FBR COAs, dividends left to accrue on all life insurance policies (including excluded policies) are countable resources, separate and apart from any CSVs. If a policy states non-participating or does not pay dividends no further development of dividends is required. Otherwise, verify from the insurance company whether a policy earns dividends and the amount of accrued dividends as of the first day of the month of verification.
PROCEDURES	Verify from the source the value of any accrued dividends as of the first moment of the first day of the month of verification.

2316 – HOMEPLACE: ABD MEDICAID

POLICY STATEMENT

A non-institutionalized A/R's homeplace, regardless of value, is excluded from resources in its entirety. An institutionalized A/R's homeplace is a countable resource, but the value will be considered exempt as long as the A/R remains institutionalized and retains ownership interests.

BASIC CONSIDERATIONS

The homeplace is property in which the A/R or a deemor has an ownership interest and that serves as the principal place of residence of the A/R, the A/R's spouse or other dependent relative.

The homeplace consists of the following:

- the shelter in which the A/R lives
- the land on which the shelter is located (home plot)
- all land which adjoins the home plot if the adjoining land is not completely separated from the home plot by land in which neither the A/R nor a deemor has an ownership interest.

  NOTE: Easements and public rights of way do ***not*** separate the property of the homeplace.

- all other buildings located on the homeplace property.

Absence for A/R's in LA-A, B, or C

When an A/R is absent from home, the property may continue to be excluded from resources as a homeplace under certain conditions.

Georgia Homeplace

If the absent A/R's home is located in Georgia, the homeplace will continue to be excluded from resources if any one of the following conditions is met:

- The A/R or PR states in writing that the A/R plans to return to the homeplace.
- The A/R's spouse or dependent relative continues to live at the homeplace while the A/R is absent.
- Sale of the homeplace would cause undue hardship to a co-owner of the homeplace because of loss of housing.

BASIC CONSIDERATIONS (cont.)

Absence from Out of State Homeplace

An out-of-state homeplace may be excluded from resources during the A/R's absence only if the A/R's spouse or dependent relative lives on the homeplace.

Absence from Homeplace for A/R's in LA-D

The homeplace of an A/R residing in LA-D is a countable resource effective the first full month that the A/R resides in LA-D. The value of the homeplace will be exempt, and will not be counted in the resource determination, as long as the A/R remains in LA-D and retains ownership interest.

NOTE: SSA does not consider a ***vacant*** homeplace to be an excluded resource for purposes of determining SSI eligibility. A vacant homeplace may be excluded as a resource for an ABD Medicaid A/R only if the A/R resides in LA-D, or a dependent relative resides in the homeplace.

A dependent relative can be a spouse, son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, grandmother, grandfather, aunt, uncle, sister, brother, stepsister, stepbrother, half-sister, half-brother, niece, nephew or cousin.

Dependency may be found where the relative alleges ***any*** reasonable degree of reliance on the A/R's homeplace. Reasonable factors of dependency are age, medical reasons, financial circumstances, etc. The degree of dependency is not material. It is not necessary to assign a dollar limitation for determining whether financial dependency exists.

PROCEDURES

Verify and document the A/R's ownership interest in homeplace property. Refer to Section 2060, ABD Medicaid Application Processing, for guidelines on completing a property search.

Place copies of any legal documents obtained via the property search or in the possession of the A/R in the case record.

Absence for LA-A, B or C

If an A/R residing in LA-A, B, or C intends to return to a homeplace, obtain the A/R's or PR's ***written*** statement for the case record.

If the spouse or dependent relative lives in a Georgia or out-of-state homeplace, document the A/R's or PR's statement. If questionable, develop further by verifying with a home visit, collateral contact, etc.

Accept and document the A/R's or PR's statement as to the degree of relationship and dependency unless questionable.

Absence for LA-D

Document ownership and the value of the homeplace. Do not count the value of the homeplace in the resource determination as long as the A/R remains in LA-D and retains ownership of the homeplace.

SPECIAL CONSIDERATIONS

Transfer of the Homeplace

Effective with OBRA '93, the homeplace is a countable resource for A/Rs in LA-D, even though the value is not considered in the resource determination. For any homeplace transferred on or after 8-11-93 (OBRA '93), presume that the transfer was made for the A/R to continue to qualify for Medicaid under OBRA '93, unless the A/R transferred the homeplace exclusively for a reason other than to qualify for Medicaid. Refer to Section 2342, Transfer of Resources.

2317 - HOMEPLACE: FAMILY MEDICAID

POLICY STATEMENT	A Family Medicaid applicant/recipient's (A/R's) homeplace, regardless of value, is an excluded resource in its entirety.
BASIC CONSIDERATIONS	A homeplace is property in which an A/R has an ownership interest and that serves as the principal place of residence of the A/R. Only **one** homeplace per AU is exempt. The homeplace includes the following: • the house, building or other shelter in which the A/R lives • the land on which the homeplace is located (home plot) • all land contiguous to the home plot **EXCEPTION:** If the A/R owns a homeplace and s/he **and** another individual jointly own land contiguous to the homeplace property, the jointly-owned contiguous property is **not** considered part of the homeplace, and is therefore **not** excluded. **NOTES:** Easements and public rights of way, including roads do **not** separate the property of the homeplace. Surrounding property separated by property owned by individuals other than the A/R is not considered part of the homeplace and is therefore not excluded. • All other outbuildings located on the homeplace property. **EXCEPTION:** Buildings on the homeplace such as other houses or businesses, which are clearly not part of the home and its outbuildings, are not excluded. Only one home and its outbuildings are exempt. The original homeplace may have been expanded by purchase of property contiguous to the homeplace, therefore, more than one deed may exist for the homeplace. These multiple deeds are considered a single homeplace provided all deeds are in the name of the A/R and/or the A/R's spouse.

BASIC CONSIDERATIONS (cont.)

The homeplace may continue to be excluded from resources when the A/R is absent from the home for any of the following reasons:

- illness
- vacation
- uninhabitability caused by natural disaster or other casualty
- employment
- training

Land or a lot purchased with the intent to build a home is excluded **only** if the AU currently does not own a home.

A partially built home is excluded **only** if the AU currently does not own a home.

Money derived from the sale of a homeplace must be reinvested in another homeplace within six months. If a new homeplace is **not** purchased, the proceeds from the sale are considered a resource and are counted in the eligibility determination. If a new homeplace **is** purchased, but the purchased price is less than the proceeds from the sale of the previous homeplace, the unspent proceeds are considered a resource and are counted in the eligibility determination.

2318 - HOME REPLACEMENT FUNDS

POLICY STATEMENT

When an individual sells an excluded home, the proceeds of the sale are excluded as a resource if the individual plans to use the proceeds to buy another home that can be excluded and does so within the appropriate time frame of receiving the proceeds.

BASIC CONSIDERATIONS

Family Medicaid

If a Family Medicaid AU sells an excluded homeplace, the proceeds derived from the sale must be reinvested in another homeplace within six (6) months. If not, the proceeds from the sale are considered a resource and counted in the eligibility determination.

ABD Medicaid

If an ABD Medicaid A/R sells an excluded homeplace, the proceeds from the sale are excluded as a resource if the individual reinvests the proceeds in another homeplace which can be excluded within three (3) full calendar months of receiving the proceeds.

NOTE: It is permissible for the ABD Medicaid A/R to reinvest the proceeds into a homeplace that will be jointly owned by the A/R and others.

If the ABD Medicaid A/R receives the proceeds from the sale of their homeplace under an installment contract, the contract is an excluded resource for as long as the following conditions are met:

- The individual plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home.
- The home is purchased within three (3) full calendar months of receiving such down payment or installment payment.

If an ABD Medicaid A/R receives the proceeds from the sale of their homeplace in a lump sum, the proceeds are the net amount the seller receives at settlement.

If paid in installments, the proceeds consist of the following:

- any down payment
- any portion of any subsequent payment that is not interest.

BASIC CONSIDERATIONS (cont.)

Use of proceeds to buy another excluded home includes payment of any costs that stem from the purchase. These include, but are not necessarily limited to, the following:

- down payment
- settlement costs
- loan processing fees and points
- moving expenses
- necessary repairs to or replacements of the new home's structure or fixtures, such as roof, furnace, plumbing, built-in appliances, that are identified and documented prior to occupancy
- mortgage payments.

Use of proceeds to pay other costs will warrant their exclusion if such costs are identified and documented prior to occupancy and stem directly from the purchase or occupancy of the new home.

NOTE: *Within three (3) full calendar months* means by the end of the last day of the third month after the month in which the proceeds are received.

Using the proceeds includes obligating them by contract as well as actually paying them out.

Lump Sum Proceeds Received by ABD Medicaid A/R's

If lump sum proceeds are not used within 3 months, the exclusion of unused funds will be revoked retroactively to the date of their receipt.

Installment Payments Received by ABD Medicaid A/R's

If installment payment proceeds are not used within 3 months, the exclusion of the installment contract itself, and of the unused portion of any installment payments, will be revoked retroactively to the date the unused proceeds were received.

The exclusion of an installment contract, once revoked, will be reinstated if the individual intends to and does use the entire principal portion of a subsequent installment payment toward the purchase of another excluded home within 3 full calendar months of receiving such installment payment.

PROCEDURES

ABD Medicaid

Explain the home replacement exclusion to any individual who has sold an excluded home (if it is not too late to exclude any of the proceeds) or who plans to do so. Include the date, if known, by which the proceeds must be used in order to qualify for the resource exclusion.

Obtain a signed statement from the individual as to whether s/he intends to use the proceeds to buy another home by the date specified. If so, the statement must also reflect his or her understanding that the exclusion of any funds not used by the date specified will be revoked retroactively.

Installment Contracts

When the proceeds are being paid in installments, the individual's statement of intent must reflect his/her understanding that, if the non-interest portion of any payment is not used within 3 months of its receipt, the exclusion of the unused portion of such payment and the contract itself will be revoked retroactively to the date of receipt of such payment.

Review at End of Exclusion Period

Create an alert to contact the individual in the last month of the exclusion period to determine if the proceeds have been committed to the purchase of a new home.

If the amount paid at settlement on the new home equals or exceeds the lump sum received for the old home, cease development of the lump sum proceeds as a resource.

Documentation

Document the system and case with a copy of the settlement sheet, contract for sale and/or evidence that shows the net proceeds of the sale and how paid or payable, such as paid in full at settlement, dates and amounts of the down payment and installment payments, interest, etc.

Document with the same type of evidence used to document the proceeds of the sale of the prior home and, if necessary, with bills, receipts, or other evidence of related allowable expenses.

PROCEDURES (cont.)

Installment Payments

Unless there is a question of unstated income or previously undetected resources, cease current development if both the following conditions are met:

- The down payment on the new home equals or exceeds the down payment received from the sale of the prior home.
- Monthly payments on the new home equal or exceed the non-interest portion of the installment payments being received on the prior home.

Lump-Sum Proceeds or Down Payment

Document use of the proceeds for related allowable expenses if either of the following occurs:

- The amount paid at settlement for the new home is less than the lump-sum proceeds of the sale of the prior home.
- The down payment on the new home is less than the down payment received from the sale of the prior home.

If all of the proceeds will **NOT** be used within 3 months, redetermine the value of countable resources for the months after the proceeds were received. Do not exclude either of the following as a countable resource:

- The unused portion of the lump-sum proceeds or down payment.
- The value of an installment contract.

2319 - HOUSEHOLD GOODS AND PERSONAL EFFECTS

POLICY STATEMENT

The countable value of household goods and personal effects is dependent on whether the ABD Medicaid class of assistance is Non-FBR or FBR.

All household goods and personal effects are excluded in Family Medicaid.

BASIC CONSIDERATIONS

Household Goods

Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home. They include furniture, appliances, television sets, carpets, cooking and eating utensils, dishes, etc.

Personal Effects

Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to him/her. They include clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments or hobby materials.

Items of Unusual Value

An item of unusual value is one whose CMV exceeds $500.

Durable Items

Durable household goods and personal effects include furniture, major appliances, expensive carpets and jewelry, and other items that retain a significant resale value over time but whose CMV does not exceed $500.

Durable items do not include the following:

- anything treated as an item of unusual value
- ordinary cooking and eating utensils
- small appliances
- linens
- clothing
- household furnishings of little value.

Non-FBR COAs

All household goods and personal effects owned by non-FBR A/Rs and deemors are excluded as resources, regardless of value.

BASIC CONSIDERATIONS (cont.)

FBR COAs

A general exclusion of up to $2,000 applies to the total equity value of household goods and personal effects other than those excluded regardless of value. Any portion of the total equity in excess of $2,000 is not excluded under this provision.

One wedding ring and one engagement ring per individual are excluded regardless of value. Additional rings are treated in accordance with the instructions below on items of unusual value.

Prosthetic devices, wheelchairs, hospital beds, dialysis machines and other items required by a person's physical condition are excluded regardless of value if they are not used extensively and primarily by other members of the household.

PROCEDURES

Non-FBR COAs

If a non-FBR alleges to own any item with a CMV in excess of $500, document his statement and exclude the item as a resource.

FBR COAs

Ask if the applicant or deemor(s) own an item(s) valued over $500. If the applicant says there are none, accept the allegation in the absence of evidence to the contrary.

Assume that the total equity value of all other household goods and personal effects is $2,000 or less. No further development is required.

If the applicant or deemor(s) allege to own any items with values in excess of $500, continue development.

Ask if the individual's physical condition require any of the items. If the answer is NO, continue development. If the answer is YES, document the following:

- what the condition is
- why the item is required for that condition (unless the reason is obvious)
- the extent to which the individual uses the item
- the extent to which any other member of the household uses them.

PROCEDURES

FBR COAs (cont.)

Determine, based on allegations, whether any of these items are excluded. If, after excluding appropriate items, the alleged total CMV of the remaining items of unusual value does not exceed $1,000, discontinue development. Otherwise, continue development.

Have the individual list all durable items and the estimated value of each. If the sum of their alleged value and the alleged value of the non-excluded items of unusual values does not exceed $2,000, cease development. If it does exceed $2,000, continue development.

Verify the CMV of any item of unusual value not excluded. Use any reliable evidence of the CMV that the individual can submit, such as a recent sales slip or appraisal, or insurance coverage, or obtain an estimate from a knowledgeable source, such as a local merchant.

NOTE: Insurance appraisals and amounts of insurance coverage often reflect replacement value rather than CMV. Do not use replacement value in lieu of CMV.

If the verified CMV of all non-excluded items of unusual value and the alleged CMV of all durable items totals $2,000 or less, cease development. Otherwise, continue development.

Determine whether any of the durable items can be excluded. If some are excluded and if the verified CMV of all non-excluded items of unusual value and the alleged CMV of the remaining durable items then totals $2,000 or less, cease development. Otherwise, continue development.

Verify the CMV of the non-excluded durable items. If the verified total CMV of all non-excluded items of unusual value and non-excluded durable items is $2,000 or less, cease development. Otherwise, continue development. If the portion of the total CMV that exceeds $2,000 affects eligibility, determine the equity value of any item on which the individual alleges there is an encumbrance. If total equity value then exceeds $2,000, that portion of the equity in excess of $2,000 cannot be excluded under this provision.

2320 - INHERITANCES AND UNPROBATED ESTATES

POLICY STATEMENT

An ownership interest in an unprobated estate may be a resource if any one of the following conditions is met:

- The individual is an heir or relative of the deceased
- The individual receives any income from the property
- The individual has acquired rights in the property due to the death of the deceased under state intestacy laws.

BASIC CONSIDERATIONS

There is an ownership interest in an unprobated estate if one of the following conditions is met:

- Documents such as a will or court record indicate an individual is an heir to property of a deceased individual.
- An individual has use of a deceased's property or receives income from it.
- Documents establish or the individual alleges a relationship between himself and the deceased that awards the individual a share in the distribution of the deceased's property under state intestacy laws and the inheritance, use of income and distribution are uncontested.

Any inheritance becomes a resource the month after the month of receipt. Refer to Section 2405, Treatment of Income, to determine if an inheritance is income in the month of receipt.

PROCEDURES

When a relative of an A/R dies intestate, use Georgia intestate laws to determine the A/R's share until the estate goes to probate court.

Exclude an interest in an unprobated estate (will or no will) from the date the estate goes to probate court. While in probate, check monthly to determine the status of the case until the case is settled; then determine CMV of A/R's share of the estate.

Document the file as applicable with the copy of the following:

- an inheritance or relationship document or signed statement alleging a relationship
- evidence of income from the property
- the individual's signed statement concerning his/her use of the property and whether any factor is contested.

GEORGIA INTESTATE LAWS

WILLS, TRUST, AND ESTATES
ARTICLE 4
ACKNOWLEDGEMENTS OF SERVICE

Effective date- This article became effective July 1, 1986.

Editor's notes - Ga. L. 1986, P.436, Sec. 2, not codified by the General Assembly, provided: "This Act shall become effective July 1, 1986, and shall apply to acknowledgements filed for record on or after its effective date."

53-3-80. Acknowledgement of service to be attested.

No acknowledgement of service in any proceeding relating to the probate of wills shall be valid unless it is attested by a notary public or the clerk of the probate court. (Code 1981, Sec. 53-3-80, enacted by Ga. L. 1986, p.436.Sec. 1)

CHAPTER 4
DESCENT AND DISTRIBUTION

Article 1

General Provision

Sec. 53-4-2. Rules on inheritance generally.

Sec. 53-4-3. Inheritance by husband, children, and descendants of intestate (Repealed).

Sec. 53-4-4. Inheritance by illegitimates and their offspring.

RESARCH REFERENCES

ALR.- Statutory or constitutional provision allowing widow but not widower to take against will and receive dower interests, allowances, homestead rights, or the like as denial of equal protection of law, 18 ALR 4th 910.

GEORGIA INTERSTATE LAWS (cont.)

ARTICLE 1
GENERAL PROVISIONS

53-4-2. Rules of inheritance generally.

The following rules shall determine who are the heirs at law of a deceased person:

(1) Upon the death of the husband or wife without lineal descendants, the surviving spouse is the sole heir and upon payment of that deceased spouse's debts, if any, may take possession of the estate without administration;

(2) If, upon the death of the husband or wife, there are children or representatives of deceased children, the surviving spouse shall have a child's part, unless the shares exceed four in number in which case, the surviving spouse shall have one-fourth part of the estate and the children shall have three-fourths' part of the estate; and the surviving spouse and children shall take per capita but the descendants of the children shall take per stirpes. In any case in which a surviving spouse is entitled to the year's support and maintenance under Chapter 5 of title 53, the amount of such support and maintenance shall not be includable in computing the amount to which that surviving spouse is entitled under this paragraph. No election by the surviving spouse shall be necessary to entitle that spouse to the portion of the estate allowed by this paragraph, but that surviving spouse shall be entitled thereto as a matter of law unless that spouse renounces such portion, in whole or in part, within nine months after death of the other spouse;

NOTE: If a spouse died prior to 7/85, the surviving spouse is entitled to a minimum of 1/5 of the estate.

The 1985 amendment effective July1, 1985, rewrote paragraph (1) and (2) formerly relating to heirs upon death of the husband, would apply to all cases in which a person dies intestate on or after July 1, 1985.

(3) Whenever the husband or wife of a deceased person is under the age of 18 years and entitled to a share in the estate of the deceased husband or wife, he or she shall be entitled to take and hold such share without the intervention of a guardian or other trustee.

GEORGIA INTERSTATE LAWS (cont.)

(4) Children shall stand in the first degree from the intestate and inherit equally all property of every description accounting for advancements as provided in Article 3 of this chapter. Posthumous children shall stand upon the same footing with children in being upon all questions of inheritance. The lineal descendants of children shall stand in the place of their deceased parents, but in all cases of inheritance from a lineal ancestor the distribution is per stirpes and not per capita;

(5) Brothers and sisters of the intestate shall stand in the second degree and shall inherit if there is no surviving spouse, child, or respresentative of a child. The half blood, both on the paternal and maternal side, shall inherit equally with the whole blood. Brothers and sisters of the whole blood, brothers and sisters of the half blood and brothers and sisters adopted by a mutual parent of the intestate shall stand in the same degree and inherit equally from each other. The children or grandchildren of deceased brothers and sisters shall request and stand in the place of their deceased parents but there shall be no representation further than this among collaterals. If all the brothers and sisters are dead at the time of death of the intestate, then the distribution shall be between the nephews and nieces per capita; and if any of the nephews and nieces are dead, leaving children, distribution shall be made as though the nephews and nieces were alive, the children of the deceased nephew or niece standing in the place of the parent;

(6) The father and mother inherit equally with brothers and sisters and stand in the same degree;

(7) In all degrees more remote than those specified in the paragraphs (1) through (6) of this code section, the paternal and maternal next of kin shall stand on an equal footing;

(8) The grandfathers and grandmothers of the intestate shall stand next in degree;

(9) Uncles and aunts shall stand next in degree with the children of any deceased uncle or aunt inheriting in the place of their parent;

(10) First cousins shall stand next in degree; and

GEORGIA INTERSTATE LAWS (cont.)

(11) The more remote degrees of kindship shall be determined by counting the steps from the claimant to the closest common ancestor and from the ancestor to the intestate. The sum of the two shall be the degree of kinship.

Term uncle as used in this section is limited to those persons who have a common ancestor with the niece or nephew.

2321 – JAPANESE AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS

POLICY STATEMENT	Permanently exclude from resources unspent portions of Japanese American and Aleutian Restitution Payments.
BASIC CONSIDERATIONS	These payments are restitution payments made by the U.S. Government to Japanese Americans and Aleutians or their survivors who were interned or relocated during World War II. **NOTE:** Interest earned on unspent portions is treated as countable income for the month available and as a resource if retained in subsequent months.
PROCEDURES	If an individual alleges that his or her resources include restitution payments, obtain a statement as to the following: • The date(s) and amount(s) of such payment(s) • The date(s) and amount(s) of any corresponding account deposits. Accept the individual's allegation in the absence of evidence to the contrary.

2322 - LIFE ESTATE AND REMAINDER INTERESTS

POLICY STATEMENT

The value of a life estate interest may or may not be a countable resource, depending on whether the A/R's ABD COA is FBR or Non-FBR.

The value of a remainder interest is a countable resource for all ABD COAs.

For Family Medicaid COAs, life estate interest that an individual has a right to use, but not dispose of during his/her life, is excluded as a countable non-liquid resource. However, consider any income received from the property.

BASIC CONSIDERATIONS

Life Estate

A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life or someone else's life. In some case, it may be conditional, such as for life or until remarriage.

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

However, some states allow life estates with powers, wherein the owner of the property creates a life estate for himself or herself retaining the power to sell the property, with a remainder interest to someone else, such as a child.

NON-FBR COAs

Exclude all life estates in real property owned by Non-FBR A/Rs.

FBR COAs

If a FBR A/R owns a life estate with powers, its resource value is its full equity value.

If a FBR A/R owns a life estate with no powers, use the table on the following page to determine the resource value.

NOTE: If the property for which an A/R owns a life estate is the A/R's principal place of residence, apply the homeplace exclusion.

BASIC CONSIDERATIONS (cont.)	
Remainder Interest	When the owner of the property gives it to one party in the form of a life estate and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property. The value of a remainder interest in non-homeplace property is a countable resource for all A/Rs.
Transfer of Resource Penalty	If an A/R transfers ownership of real property and retains life interest, he/she has transferred remainder interest. Consider a transfer of resources penalty on the value of the remainder interest. If an A/R transfers life interest, consider a transfer of resources penalty on the value of the life interest. See Section 2342, Transfer of Resources.
PROCEDURES	Obtain copies of legal documents which convey the life estate or remainder interest. Exclude as a resource any life estate interest in real property owned by a Non-FBR A/R. Verify the CMV of any property in which a FBR A/R owns a life estate interest, or any liquid asset in which a Non-FBR A/R owns a life estate interest, or in which ANY A/R owns a remainder interest.

Use the following chart to determine the resource value of a life estate or remainder interest. Multiply the CMV of the property by the life estate or remainder interest decimal that corresponds to the life estate interest holder's age. Always use the life estater's age to determine the value of a life estate or remainder interest.

Chart 2322.1 UNISEX LIFE ESTATE OR REMAINDER INTEREST TABLE		
AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198.	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	..97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540

Chart 2322.1 UNISEX LIFE ESTATE OR REMAINDER INTEREST TABLE		
AGE	LIFE ESTATE	REMAINDER
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.10731
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951

Chart 2322.1 UNISEX LIFE ESTATE OR REMAINDER INTEREST TABLE		
AGE	LIFE ESTATE	REMAINDER
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.33262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.29655	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

2323- LIFE INSURANCE POLICIES

POLICY STATEMENT

A life insurance policy is a resource if it has a cash surrender value (CSV). Its value as a resource is the amount of the CSV. The CSV of some policies may be excluded in ABD Medicaid.

This is an excluded resource for Family Medicaid.

BASIC CONSIDERATIONS

Cash Surrender Value

The CSV is a form of equity value that the policy acquires over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or before the insured dies. A loan against a policy reduces its CSV. In some cases, penalties may be applied for early access of funds. These penalties are deducted from the value of the resource to determine the cash value available.

Term insurance policies that do not generate a CSV are not resources.

Burial insurance policies are not resources if the owner does not have access to the CSV. A burial insurance policy is a contract with terms that preclude the use of its proceeds for anything other than payment of the insured's burial expense.

NOTE: For Non-FBR ABD Medicaid COAs, exclude from resources the entire cash value of any life insurance policy that has been purchased to fund a prepaid burial contract. A copy of the prepaid contract and life insurance policy is required for verification/documentation. In order to be excluded, the face value of the policy should be equal to the amount of the burial contract.

If a burial policy has a CSV to which the owner has access, the policy is considered to be a life insurance policy.

A supplementary contract is not a life insurance policy. Supplementary contracts normally provide for an annuity. Treat such contracts in accordance with the instructions on filing for other benefits, just as an IRA or other type of retirement fund.

Face Value (FV)

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 this policy, the sum insured, etc.

BASIC CONSIDERATIONS (cont.)

Face Value (FV) (cont.)

A policy's FV does not include the following:

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

Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV. The table of CSVs that comes with the policy does not reflect the added CSV of any dividend additions.

Dividend additions are not included in the face value amount used to determine whether a life insurance policy is an excluded resource. Refer to PROCEDURES in this section for more information on dividends paid on life insurance policies.

Exclusions

The resource exclusion for life insurance policies which have accessible CSV's depends upon whether an A/R's COAs is Non-FBR or FBR.

PROCEDURES

ABD Medicaid Non-FBR COAs

Exclude from resources the CSV of any life insurance policy owned by a Non-FBR A/R or deemor that has a face value of $5000 or less. There is no limit to the number of policies that may be excluded as long as the face value of each policy is $5000 or less.

NOTE: For Non-FBR A/Rs, funds set aside for burial are not subject to reduction by the face value of these excluded policies.

Exclusion for ABD Medicaid FBR COAs

For FBR A/R's, exclude from resources the accessible CSV of a life insurance policy owned by the A/R if its face value (FV) and the FV of all other life insurance policies with the accessible CSVs owned by the A/R on the same individual is a total of $1500 or less.

A FBR A/R may own up to a total of $1500 FV life insurance on each individual and still be entitled to the exclusion.

NOTE: For FBR A/R's, funds set aside for burial are not subject to reduction by the face value of all excluded policies.

PROCEDURES (cont.)

Verification and Documentation For ABD Medicaid

Require the A/R to submit all life insurance policies owned by the A/R and deemors.

Document all policies on the system.

Verify the following items on all life insurance policies:

- the owner
- the insured
- the FV
- whether the policy generates a CSV and, if it does, the current CSV, not counting the CSV of any dividend additions.

Make copies of pages from policies which show the above information. If a policy does not reveal any item, contact the insurance agent or company by telephone, letter or Form 106.

Additional Verification Requirements for ABD Medicaid FBR COAs

In addition to the above items, verify the following on all policies owned by FBR A/Rs:

- whether the policy pays dividends and, if it does, what option the individual selected for their disposition, such as accumulation, dividend additions, applied to premiums or paid directly to the A/R by check.
- the CSV of any dividend additions
- the current amount and interest earned on any dividend accumulations.

Dividends

Unless there is evidence to the contrary, assume the following to be true:

- A policy issued by a non-participating or stock company does not pay dividends.
- A policy issued by a participating or mutual company pays dividends.

NOTE: Identification of the kind of company usually follows its name on the face page of the policy.

If the examination of a policy does not reveal this information, obtain the information by telephone, letter or Form 106 from the insurance agency or company.

Refer to Section 2315, Dividends, Accrued, for information on the resource treatment of dividends paid on life insurance policies.

2324 - LUMP SUMS

POLICY STATEMENT	Money received in the form of a lump sum that is not expected to recur, i.e. rebates, retroactive or corrective payments for prior months, insurance settlements, federal or state tax refunds.
BASIC CONSIDERATIONS	Lump Sums are counted as income the month of receipt. Any remainder counts as a resource beginning the month after the month of receipt. **EXCEPTION:** Unspent RSDI or SSI lump sums are excluded resources for six full calendar months after receipt. Interest earned on unspent RSDI or SSI lump sums is not excluded as income. Refer to Section 2305, Commingled Funds, if unspent RSDI or SSI lump sums are commingled with other funds.
PROCERURES	For all lump sums, verify the amount and date of receipt from the source of the payment.

2325 - PATIENT FUND ACCOUNT (NH)

POLICY STATEMENT	A nursing home patient fund account is treated as any other financial account. The balance of the account as of the first moment of the first day of the month is a countable resource. This is not applicable to Family Medicaid with the exception of a LIM individual in a nursing home.
BASIC CONSIDERATIONS	A nursing home patient fund account is a bank account set up by the nursing home for the convenience of the patient. A nursing home holding a patient fund account with a balance of $50 or less is not required to pay interest on the account. Refer to Interest in Chart 2399.1, Treatment of Income in ABD Medicaid, for the income treatment of any interest earned on a patient fund account containing more than $50.
PROCEDURES	On every application and redetermination, verify by telephone or Form 958 whether a NH A/R has an account and the account balance as of the first moment of the first day of the month of application or review. Document the system appropriately.

2326 - PREPAYMENTS AND DEPOSITS (NH)

POLICY STATEMENT	If a nursing home refunds a prepayment or deposit to an A/R, the amount of the refund is a countable resource at application and is treated as a savings account. This is not applicable to Family Medicaid with the exception of a LIM individual in a nursing home.
BASIC CONSIDERATIONS	Prepayments or deposits are collected by NHs in the event an applicant's ABD Medicaid application is denied. These prepayments/deposits are usually refunded if the application is approved. If a prepayment/deposit was made by someone other than the A/R and will be refunded to the other individual, the refund has no effect on the A/R's eligibility.
PROCEDURES	On every applicant in a NH, verify whether a prepayment or deposit was made to the NH, to whom a refund will be made and the amount of the expected refund. Verify by telephone or Form 958. Document the system appropriately.

2327 - PROPERTY ESSENTIAL TO SELF-SUPPORT

POLICY STATEMENT

Personal or non-homeplace real property that produces income, goods or services may be partially or totally excluded.

BASIC CONSIDERATIONS

Current Use Requirements

Property, including property used by an individual as an employee, must be in current use in the type of activity that qualifies it as essential to be excluded as essential to self- support. Current use is evaluated on a monthly basis. Property not in current use can be excluded as essential to self-support only if the following conditions are met:

- It has been in use
- There is a reasonable expectation that the use will resume.

Resumption of use must be expected within 12 months of last use. For example, if property was last used in October, resumption of use must reasonably be expected to occur before the end of the following October.

The 12 month period can be extended for an additional 12 months if non-use is due to a disabling condition.

Categories of Property Essential to Self Support

There are three categories of property essential to self-support:

- *Business Property*, such as the following:
  - property used in a trade or business, such as farmland, barber shop, etc.
  - property that represents government authority to engage in an income producing activity, such as commercial fishing permits, tobacco crop allotments
  - property used by an individual as an employee for work, such as the tools of an employed mechanic.
- Non-business property used to produce goods or services for home consumption, such as land or equipment used to produce vegetables or livestock solely for home consumption.
- Non-business income producing property such as rental property that produces a net annual return.

PROCEDURES

Business Property

Totally exclude business property as a resource, regardless of its value or rate of return.

FBR and Non-FBR COAs

When an individual alleges owning trade or business property not already being excluded, consider if a valid trade or business exists and whether the property is in current use. Obtain a statement giving the information below:

- a description of the trade or business
- a description of the assets of the trade or business
- the number of years it has been operating
- the identity of any co-owners.

Obtain a copy of the business tax return (Form 1040 and the appropriate schedules) for the tax year prior to the application or redetermination. Use the return to determine the net earnings from self- employment and validity of the trade or business. The following can be particularly helpful:

- Schedule C, Profit or Loss from Business or Profession
- Schedule SE, Computation of Social Security Self-employment
- Schedule F, Farm Income and Expenses
- Form 4562, Depreciation and Amortization
- Form 1065, U.S. Partnership Return of Income.

If the current tax return is not available, obtain a copy of the latest tax return available.

Property That Produces Goods/Services for Home Consumption

FBR & Non-FBR COAs

Exclude as a resource up to $6000 of the equity value of non-business property used to produce goods or services for home consumption, regardless of the rate of return. Any portion of the equity value in excess of $6000 is a countable resource.

NOTE: While this category of property may encompass a vehicle used solely in a non-business self-support activity, such as a garden tractor or boat used for subsistence fishing, it does not include any vehicle that qualifies as an automobile.

PROCEDURES

Property That Produces Goods/Services for Home Consumption (cont.)

When an individual alleges owning property that he or she uses to produce goods or services necessary for daily activities, obtain his or her statement on the following:

- a description of the property
- how it is used
- an estimate of its CMV and any encumbrances.

If evidence to the contrary is absence, accept their statement.

Determine the CMV of real property and, if necessary, the EV of real property.

Have the individual obtain a CMV estimate of personal property from a knowledgeable source. The estimate must include the following:

- the identity of the source of the statement
- a description of the item whose CMV is being estimated
- the basis for the estimate.

NOTE: If a knowledgeable source provides a value range, use the lower end of the range.

Non-Business Income Producing Property

When an individual alleges owning non-business real property that produces income such as land or a house for rent, obtain his or her signed statement on the following:

- the number of years s/he has owned the property
- any co-owners of the property
- a description of the property
- the estimated CMV of the property and any encumbrances on it
- the estimated net and gross income from the property for the current year.

If evidence to the contrary is absence, accept the individual's statement with respect to years of ownership, identity of owners and description of the property.

PROCEDURES (cont.)

Non-FBR COAs

For Non-FBR COAs, totally exclude non-business income producing property as a resource, regardless of the rate of return.

Verify and document that the property is producing income.

NOTE: Count the net income (profit) produced by this property, if any, as unearned income.

FBR COAs

For FBR COAs, exclude up to $6000 of the equity value of non-business income producing property as a resource only if the property produces a net annual return of at least 6% of the excluded portion. Any portion in excess of $6000 is a countable resource.

If an individual owns more than one piece of non-business income producing property, apply the following rules:

- The 6% return requirement applies individually to each
- The $6000 EV limit applies to the total EV of all properties meeting the 6% return requirement

If all properties meet the 6% test but the total EV exceeds $6000, that portion of the total EV in excess of $6000 is not excluded under this provision.

Determine the rate of return based on income and value figures shown on the individual's Schedule E (Supplemental Income Schedule) of Form 1040 for the year prior to filing of the application. If no tax return is available, obtain other appropriate evidence from the individual, such as a copy of the lease agreement for the period in question.

NOTE: When redetermining the status of property already excluded under this provision, only the value and income need to be redeveloped.

SPECIAL CONSIDERATIONS for Business Property

Government Permits

If an individual alleges owning a government license, permit, or other property that represents government authority to engage in an income producing activity, and that has value as a resource, obtain his or her signed statement as to the following:

- the type of license, permit, or other property
- the name of the issuing agency, if appropriate
- whether the law requires such license, permit, or property for engaging in the income producing activity at issue
- how the license, permit, or other property is being used, or
- if it is not being used, why not.

Have the individual submit a copy of the license, permit, and/or other pertinent documents. For example, an individual engaged in fishing in Alaska would have a permit. In North Carolina, a person growing flue-cured tobacco would have a marketing sales card to sell it. If the individual cannot submit the necessary evidence, verify his or her allegations with the issuing agency. Do this by telephone if possible.

Tobacco Crop Allotment (TCA)

The TCA is the other most commonly encountered type of property representing government authority to engage in an income producing activity. It is issued by the U.S. Department of Agriculture's Agricultural Stabilization and Conservation Service. It is required for the growing and selling of flue-cured tobacco, which is grown mostly in the southeastern United States. Do not confuse a TCA with a price support or subsidy, or a soil bank program.

Exclude a TCA only when the grower who has it is restricted to growing a certain quantity of the crop.

Items Used for Employment

If an individual alleges owning items that are used in his or her work as an employee, obtain his or her statement on the following:

- the name, address, and telephone number of the employer
- a general description of the items
- a general description of his or her duties
- whether the items are currently being used.

Absent evidence to the contrary, accept the individual's statement.

SPECIAL CONSIDERATIONS (cont.)

Liquid Resource Used in a Trade or Business

All or a portion of a liquid resource used in the operation of a trade or business, such as a checking account, can be excluded from resources. This applies to all classes of assistance.

- Obtain the A/R's signed allegation that the liquid resource is used in a trade or business.
- Obtain verification of average monthly business expenditures in order to determine what portion of the resource is used in the trade or business.
- Exclude up to three times the average monthly business expenditures as the portion of the liquid resource used in the trade or business.

2328 – PROPERTY RIGHTS

POLICY STATEMENT	Property rights are treated as real property in determining resource eligibility.
BASIC CONSIDERATIONS	Property rights can be in any of the following forms.
Mineral Rights	Mineral rights represent an ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.
Timber Rights	Timber rights permit one party to cut and remove free standing trees from the property of another party.
Easements	An easement gives one party the right to use land of another party for a special purpose.
Leaseholds	A leasehold gives one party control over certain property of another party for a specified period. In some states, a *lease for life* can create a life estate under common law.
Water Rights	Water rights usually confer upon the owner of river front or shore front property the right to access and use the adjacent water.
PROCEDURES	Verify the ownership and equity value of property rights. If the individual owns the land to which the mineral rights pertain, the CMV of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary. If the individual does not own the land to which the mineral rights pertain, obtain a CMV estimate from a knowledgeable source. Such sources include the following: • the Bureau of Land Management • the U.S. Geological Survey • any mining company that holds leases. Refer any *lease for life* agreement to the Medicaid Unit for a determination of whether it creates a life estate.

2329 - REAL PROPERTY: NON-HOMEPLACE

POLICY STATEMENT

The equity value of the applicant/recipient's (A/R's) interest in non-homeplace real property is a countable resource for all ABD and Family Medicaid Classes of Assistance (COAs).

BASIC CONSIDERATIONS

Non-homeplace real property includes the following:

- land
- lots
- trees on land
- buildings on non-homeplace property which would transfer to a buyer if/when the land or lot were sold
- houses and mobile homes, whether occupied or unoccupied

Equity value (fair market value less any indebtedness) is the countable value of non-homeplace property.

Indebtedness is the total amount of debt that remains to be paid, including principal, interest and any liens and/or encumbrances.

Non homeplace real property may be totally or partially excluded if it meets one of the following conditions:

- the property is jointly owned and the sale of the property would cause undue hardship to a co-owner(s). Refer to Section 2304, Treatment of Resources
- the A/R is making a bona-fide or good faith effort to sell the property. Refer to Section 2304, Treatment of Resources
- the property is restricted allotted Indian land. Refer to Section 2304, Treatment of Resources
- the property meets undue hardship provisions. Refer to Section 2304, Treatment of Resources
- the property is essential to self-support (this applies only to ABD COAs). Refer to Section 2327, Property Essential to Self-Support
- the property is declared unmarketable by a competent authority
- the A/R owns a life estate interest in the property (ABD Non-FBR COAs only). Refer to 2322, Life Estate and Reminder Interests.

BASIC CONSIDERATIONS (cont.)

Sale of Non-Homeplace Real Property

The proceeds from the sale of excluded non-homeplace real property are excluded during the month of sale. Any proceeds remaining the month following the sale are a countable resource.

Bona-fide or Good Faith Effort to Sell

A bona-fide or good faith effort to sell is defined as follows:

- actual sale attempt at a price not more than current market value
- listing with a realtor

OR

- appropriate advertising such as in newspapers, radio, etc.
- acceptance of any reasonable offer.

Income Producing Property: ABD Medicaid

Refer to Section 2327, Property Essential to Self-Support.

Income Producing Property: Family Medicaid

Income producing property is considered a countable resource when determining eligibility for Family Medicaid COAs.

Income producing property is defined as follows:

- property which produces income, even if used only on a seasonal basis
- property essential to the employment or self-employment of a household member (rental homes, farm land, etc.)
- rental property which is used for vacation purposes at some time during the year and which produces income
- installment contracts for the sale of land or buildings if the contract or agreement produces income.

PROCEDURES

Verify ownership interest and Current Market Value (CMV) of non-homeplace real property using one of the following documents:

- property search (Form 991)
- legal documents indicating value of the property.

Determine the equity value of the property.

If the A/R rebuts the CMV indicated in the Tax Digest, the A/R may obtain written appraisals or estimates from two reliable sources, such as realtors or appraisers, as to the accurate CMV. Average the two appraisals or estimates to determine CMV.

2330 - RELOCATION ASSISTANCE

POLICY STATEMENT	Effective for resource determinations made for the month of May 1991 and subsequent months through April 1994, unspent relocation assistance payments from a state or local government which are received through April 1994 are excluded from resources for 9 months. The last month for which this resource exclusion may apply is April 1994. This is an excluded resource for Family Medicaid.
BASIC CONSIDERATIONS	To be excluded from the resources under this provision, the payments must be of the type described under *Federal Programs, Miscellaneous*, in Chart 2399.1, Treatment of Income in ABD Medicaid. Payments received after July 1993 cannot be excluded under this provision for the full 9-month period but only through April 1994. Interest earned on unspent relocation assistance payments is not excluded from income or resources by this provision.
PROCEDURES	If an individual alleges that his or her resources included unspent relocation assistance payments from a state or local government, complete the following procedures: • Document the date(s) and amount(s) of such payment(s). • Obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments. Refer to Section 2305, Commingled Funds.

2331 – REPAIR/REPLACEMENT FUNDS

POLICY STATEMENT	Cash and in-kind items received for the repair or replacement of lost, damaged, or stolen excluded resources may be excluded from resources for up to 18 calendar months. This is an excluded resource for Family Medicaid.
BASIC CONSIDERATIONS	Cash and in-kind items received for the repair or replacement of lost, damaged or stolen excluded resources may come from any source, such as an insurance company, a federal or state agency, a public or private organization or an individual. These funds include ISM or funds for the purchase of temporary housing but do not include funds received for personal injury. **NOTE:** These funds do not include Federal Disaster Assistance. Refer to Section 2314, Disaster Assistance. The above unspent funds are excluded resources for 9 months from the date of their receipt. To be excluded from resources under this provision, the funds must be excluded from countable income. Unspent cash receipts for the repair or replacement of excluded resources can be excluded from resources for up to an additional 9 months if, for the first 9 months, circumstances beyond the individual's control hinder the following actions: • repair or replacement of the damaged or destroyed property • contracting for such repair or replacement. What the individual intends to do with the funds does not affect their exclusion for the first 9 months. An individual cannot qualify for an extension of the original 9-month exclusion unless he or she intends to use the funds for their designated purpose. The extension will terminate as of the date of the change of intent. The previously excluded funds will be taken into account in determining resources for the following month. Interest earned by funds excluded under this provision is excluded from income and from resources for as long as the funds themselves are excluded.

PROCEDURES

Obtain a copy of any evidence the individual has.

- The evidence must show the source, value, date(s), and intended purpose of the item received, including whether any cash received is for a purpose other than the replacement or repair of the lost, damaged, or stolen (and excluded) resource.

- Evidence that establishes the ability of funds to be excluded from income also establishes their ability to be excluded from resources. Refer to Section 2405, Treatment of Income, and Section 2504, Determining Countable Income.

- If the individual cannot provide evidence sufficient for a determination, obtain the necessary information from the source of the payment(s).

Summarize the basis for the exclusion. Show the amount excluded and the first and last day of the exclusion period.

Schedule an alert to contact the A/R at least 30 days before the exclusion expires.

Obtain evidence of the amount of excluded assistance still unspent.

If assistance remains unspent but the individual alleges good cause and plans to use the funds for their intended repairs or replacement, obtain his or her signed statement. Have the individual submit evidence to substantiate the allegation of good cause.

If the evidence does not establish good cause, include the unspent assistance in determining countable resources as of the first moment of the first day of the month after the month in which the exclusion period expires.

If the evidence shows good cause, discuss with the individual how much additional time is needed and why. On the basis of that discussion, extend the exclusion period for up to an additional 9 months, repeating the development steps above.

2332 – RETIREMENT FUNDS

POLICY STATEMENT

A retirement fund owned by an eligible individual is a countable resource if s/he has the option of withdrawing the fund as a lump sum, even if s/he is not eligible for periodic payments.

BASIC CONSIDERATIONS

Retirement funds are annuities or work-related plans for providing income when employment ends, such as a pension, disability or retirement plan administered by an employer or union. Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans. Also, depending on the requirements established by the employer, some profit sharing plans may qualify as retirement funds.

Periodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly) and which result from entitlement under a retirement fund.

NOTE: Periodic retirement benefits do not include the receipt of interest only.

The value of a retirement fund is the amount of money that an individual can currently withdraw from the fund. If there is a penalty for early withdrawal, the fund's value is the amount available to an individual after the penalty deduction. Any income taxes incurred by the withdrawal are not deductible in determining the fund's value. However, if the individual is eligible for and receives periodic payments, the retirement fund is excluded as a countable resource.

To be eligible for ABD Medicaid, an individual must apply for periodic benefits. If s/he has a choice between periodic payments and a lump sum, they must choose the periodic payments.

A retirement fund is not a countable resource if an individual must terminate employment in order to obtain any payment from the fund.

A previously unavailable retirement fund is not income to its recipient when the fund becomes available. The fund is subject to resource counting rules in the month following the month in which it first becomes available.

BASIC CONSIDERATIONS (cont.)

A resource determination for the month following that in which a retirement fund becomes available for withdrawal must include the fund's value. A delay in payment for reasons beyond the individual's control, such as an organization's processing time, does not mean that the fund is not a resource since the individual is legally able to obtain the money. It is a non-liquid resource.

If an individual receives a denial on a claim for periodic retirement payments but can withdraw the funds in a lump sum, include the fund's lump sum value in the resource determination for the month following that in which the individual receives the denial notice.

If an ineligible spouse, parent or spouse of parent owns a retirement fund, the value is excluded as a countable resource.

PROCEDURES

If an individual has a retirement fund, determine and document whether he/she is eligible for periodic payments. If not, determine and document whether he/she can make a lump-sum withdrawal.

If an individual is eligible for and receiving periodic payments from a retirement fund, budget the payments as income.

If an individual is eligible for periodic payments but refuses to accept them, count the value of the retirement fund as a resource.

2333 – SAFE DEPOSIT BOX

POLICY STATEMENT	The contents of a safe deposit box may include undisclosed countable resources and/or legal documents necessary for resource verification.
BASIC CONSIDERATIONS	A safe deposit box is a strong metal container for storing valuable papers, jewels, or keepsakes, in a bank. If an A/R alleges not having a safe deposit box, no further development is required *unless* it is necessary to send a Form 957 to a financial institution for verification of checking or savings accounts. *Always* check the entry, Does the person have a safe deposit box...?, when a Form 957 is required.
PROCEDURES	
ABD Medicaid Non-FBR COAs	If a non-FBR A/R alleges having a safe deposit box, ask the A/R or PR to itemize the contents of the box on Form 989. If necessary require the A/R or PR to submit any document(s) for verification purposes. Exclude any household goods and personal effects kept in the box. *If the A/R or PR's statement of contents is questionable,* follow the procedures below for FBR A/Rs.
ABD Medicaid FBR COAs	If a FBR A/R alleges to have a safe deposit box, the contents must be inventoried. Complete a physical inventory or get a sworn statement from a bank official. Form 989 may be used for this purpose.
Family Medicaid	Accept the A/R's sworn statement as to the contents of a safe deposit box.

2334 – SAVINGS AND CHECKING ACCOUNTS

POLICY STATEMENT

The resource value of a savings instrument with a financial institution or NH is the balance of the account, *less* any early withdrawal penalty.

BASIC CONSIDERATIONS

The term savings encompasses the following:

- cash savings on hand
- checking and savings accounts
- certificates of deposit (CDs)
- credit union accounts
- time deposits
- NH patient fund accounts
- NH prepayments/deposits if to be returned to A/R
- individual retirement accounts (IRAs)
- Keoghs.

Any cash on hand received in a prior month and retained after the month of receipt is a resource.

NOTE: For the treatment of retirement funds, including IRAs and Keoghs, see Section 2332, Retirement Funds.

Verification and Documentation

Family Medicaid

Accept the A/R's statement of account balance(s) unless questionable.

ABD Medicaid

At application obtain financial statements that will verify account balance(s) as of the first moment of the first day of each month Medicaid eligibility is requested. For A/Rs alleging to have accounts with financial institutions, obtain copies of statements and/or updated passbooks.

If the A/R's *past financial history is questionable,* it is reasonable at initial application to request financial statements for a minimum of three months prior to the first month that Medicaid eligibility is requested in order to establish a history of financial transactions

PROCEDURES

Verification and Documentation

ABD Medicaid (cont.)

For NH A/Rs, verify ownership and balance of patient fund accounts by telephone or Form 958 on every application and redetermination, regardless of whether the A/R alleges having a patient fund account.

If the above records are available, and if they appear accurate and complete, calculate the balance(s) as of the first moment of the first day of the verification month. Take into consideration any deposits, withdrawals or checks that have been written that are reflected on check stubs/passbooks that are not reflected on the account statement.

If the accuracy, reliability or completeness of the account statement and the A/R's personal records is questionable, a Form 957, MAO Resource Clearance Form, must be completed by the institution. Form 957 must indicate the balance as of the first moment of the first day of the month.

Inquire as to the disposition of previously owned accounts and develop as necessary.

Check available IEVS IRS matches on each review for unreported accounts.

SPECIAL CONSIDERATIONS

Joint Accounts ABD Medicaid

If an A/R's or deemor's name appears on any checking or savings account, including an account under several names, assume that the A/R is an owner of the account unless the A/R verifies otherwise through the rebuttal process. Refer to *Joint Account Ownership Rebuttal* in this section for rebuttal procedures.

If an account is owned jointly by one or more Medicaid A/Rs and one or more non-Medicaid individuals, count all of the funds in the account as a resource to the Medicaid A/Rs in equal shares. Do *not* allow a share of the funds to the non-Medicaid individuals.

SPECIAL CONSIDERATIONS

Joint Accounts ABD Medicaid (cont.)

Assume that an A/R with ownership interest in a checking or savings account has unrestricted access to the account unless the A/R verifies restricted access through the rebuttal process. Refer to *Unrestricted Access Rebuttal* in this section for rebuttal procedures.

Joint Accounts Family Medicaid

When an AU of Family Medicaid Budget Group member is named on a joint bank account with a non-AU or BG individual solely for the convenience or emergency, exclude the joint account as a resource to the Family Medicaid AU or BG member if the other individual, or someone who is in a position to know, verifies that s/he has deposited all the money in the account and all withdrawals are used for the non-AU or non-BG individual's benefit.

Joint Account Ownership Rebuttal

If an individual wishes to rebut the applicable ownership assumption, obtain his or her statement regarding the following:

- who owns the funds
- why there is a joint account
- who has made deposits to and withdrawals from the account
- how withdrawals have been spent.

In addition, inform the individual that he or she must submit the following evidence within 30 days:

- a corroborating statement from each other account holder

  NOTE: If the only other account holder is incompetent or a minor, have the individual submit a corroborating statement from anyone aware of the circumstances surrounding establishment of the account.

SPECIAL CONSIDERATIONS

Joint Account Ownership Rebuttal (cont.)

- account records showing a history of deposits, withdrawals and interest payments.
- if the individual owns none of the funds, evidence showing that he or she can no longer withdraw funds from the account, such as removal of the individual's name from the account.
- if the individual owns only a portion of the funds, evidence showing removal from the account of such funds, or removal of the funds owned by the other account of such funds, or removal of the funds owned by the other account holder(s) and re-designation of the account.

Exclude from the A/R's resources any funds that the evidence establishes were owned by the other account holder(s) and can no longer be withdrawn from the account by the A/R.

EXCEPTION: Such funds are a countable resource in determining the A/R's resource eligibility if the account holder to whom they belong is a deemor.

Withdrawals by other Account Holder(s)

Develop a transfer of resources penalty for any withdrawals made on or after 8-11-93 by the other account holder if the A/R has not successfully rebutted ownership. Refer to Section 2342, Transfer of Resources.

EXCEPTION: In Family Medicaid there is no penalty for transferring resources. Consider only resources owned by the AU at the time of the eligibility determination.

Unrestricted Access Rebuttal

If an A/R verifies through the financial institution that s/he cannot withdraw funds from a checking or savings account without the signature of the other joint owner(s), consider the A/R to have restricted access to the account, and exclude the account from the A/R's countable resources.

EXCEPTION: If a *restricted* account is owned jointly by an A/R and deemor only, the account is a countable resource.

2335 – STOCKS AND MUTUAL FUND SHARES

POLICY STATEMENT	The value of shares of stock and mutual funds is a countable resource. **EXCEPTION:** Shares of stock in an Alaskan native regional or village corporation are excluded as resources.
BASIC CONSIDERATIONS	Shares of *stock* represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. The following guidelines apply to all types of stock, including preferred stock, warrants and rights, and options to purchase stock. A *mutual fund* is a company whose primary business is buying and selling securities and other investments. Shares in a mutual fund represent ownership in the investment held by the fund.
PROCEDURES	Verify and document the following: • Ownership Interest: If the shares are owned jointly, assume that each owner owns an equal share. • Number of Shares Owned: Ask the individual to submit the stock certificate or most recent statement of account (including dividend account) from the firm that issued or is holding the stock. Document the system and case with a photocopy. If the individual does not have this documentation, have him/her obtain a statement from the firm. Provide assistance as needed.

PROCEDURES (cont.)

Determine the countable resource value of shares of stock or mutual funds by multiplying the number of shares owned by the CMV of each share.

- Current Market Value (CMV) of Each Share: The CMV of a stock as of the first moment of a given month is its closing price on the last business day of the preceding month. The value of over-the counter stock is shown on a *bid* and *asked* basis. Use the *bid* price as the CMV. The *par value* or *stated value* shown on some stock certificates is not the market value of the stock.

- Consider the CMV of a mutual fund share to be the selling price (sell).

The closing price of a stock on a given day can usually be found in the next day's newspaper.

If the value of a stock does not appear in a newspaper, contact a local securities firm. Provide the firm with the following information:

- name of stock, bond, or mutual fund
- type of stock, such as preferred or common
- months for which values are needed.

2336 – TRUST PROPERTY, MEDICAID QUALIFYING (Prior to OBRA '93)

POLICY STATEMENT

Effective January 1, 1988, a trust which meets the definition of a Medicaid Qualifying Trust (MQT) is a countable asset.

NOTE: This policy applies ONLY to trusts created prior to 8-11-93 (OBRA '93). Refer to Section 2337, Trust Property – OBRA '93, for trusts created on or after 8-11-93. Also refer to Section 2338, Trust Property, for trusts created by a will.

EXCEPTION: Not applicable in Family Medicaid.

BASIC CONSIDERATIONS

A MQT is a trust or similar legal device established by an *individual* (or his or her spouse) under which (a) the individual is the beneficiary of all or part of the payments from the trust, **and** (b) the amount of such distribution is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed to the individual. The distributable amount from a MQT has no *use* limitation, and MQTs include trusts that are irrevocable or revocable or which are for purposes other than to enable the individual to qualify for Medicaid.

Because there are no *use* limits on the trust funds in a MQT, trusts such as irrevocable burial trusts, education trusts, and medical trusts could be MQTs, provided they meet the criteria as specified in the definition. For example, the terms of the trust may be written so that the trustee may make payments directly to the health care provider for medical services. Thus, although the payments from the trust are not directly paid to the beneficiary, s/he is in fact receiving benefits from payments.

The *individual* is the person who both establishes the trust (or whose spouse establishes the trust) and is beneficiary of the trust. A trust that is established by an individual's guardian or legal representative, acting on the individual's behalf, falls under the definition of a MQT. If an individual is not legally competent, for example, a trust established by their legal guardian (including a parent) using the individual's assets can be treated as having been established by the individual, since the individual could not establish the trust for himself.

BASIC CONSIDERATIONIS (cont.)

NOTE: A trust meeting the definition of a MQT established prior to April 7, 1986 for an individual residing in an intermediate care facility (ICF) for the mentally retarded is *not* considered a MQT. A trust established by a will is *never* treated as a MQT.

The distributable amount of the trust is the maximum amount considered *available* to be distributed to the beneficiary under the terms of the trust if the trustee exercises his full discretion.

Any portion of the available amount, principal or interest, that is distributed to the A/R for any purpose is income to the A/R for the month received and is a resource in the following month if retained.

Any portion of the available amount, principal or interest, that is not distributed to the A/R is a resource to the A/R.

Any portion of the trust assets, principal or interest, not considered available to the A/R under the terms of the trust is to be reviewed under the transfer of assets policy. Refer to Section 2342, Transfer of Resources. Also, refer to Undue Hardship Provision in Section 2304, Treatment of Resources.

Definitions

Definitions of common terms used in describing trusts:

Similar Legal Devices – any arrangements, instruments or devices which are established by the A/R or their spouse which are not called trusts or which do not qualify as trusts under state law, but which have all of the characteristics described in the definition of a MQT.

Trustee – a trustee is any individual, individuals, or entity (such as an insurance company or bank) that manages a trust or similar device and has fiduciary responsibilities.

Disbursemenets – Any money generated by the trust.

BASIC CONSIDERATIONS

Definitions (cont.)

Grantor – an individual who creates a trust. The term *grantor* includes:

- the individual
- the individual's spouse
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse
- a person, including a court or administrative body acting at the direction or upon the request of the individual, or the individual's spouse.

Beneficiary or grantee – the person on whom the money in the trust is to be spent, the person specified in the trust whose needs are to be met. In a MQT, the grantor and beneficiary are the same person (the A/R or a deemor).

Corpus or principal – the assets that make up the trust.

Encroach upon, or encroachment – the ability to access and use the assets in the trust. The trust document might say *the trustee shall have the right to encroach upon the corpus of the trust as deemed necessary for the benefit of the grantee.*

Proceeds – the money earned on the corpus, usually interest, dividends or rent.

PROCEDURES

Follow the steps below to determine the treatment of a MQT:

Step 1 Obtain a copy of the trust document and any supporting information detailing any investments and a history of distributions made by the trustee.

Step 2 Determine if the trust meets the definition of a MQT, such as who set up the trust and who is the beneficiary of the trust. Proceed to Step 3, if the trust is determined to be a MQT.

Step 3 Obtain supporting information detailing investments and a history of distributions made by the trustee.

Step 4 Determine the total amount considered available to the A/R, if any. Determine the amount(s) actually distributed to the A/R and at what interval(s).

PROCEDURES (cont.)

Step 5	Treat the amount the A/R actually receives as income in the month received and as a resource if retained in any month past the month of receipt. Treat any portion of the amount available to be distributed that is not actually distributed to the A/R as a resource to the A/R as a resource to the A/R.
Step 6	Develop a transfer of assets penalty if a portion of the trust assets is not available to the A/R.

2337 – TRUST PROPERTY – OBRA '93

POLICY STATEMENT

Effective with all trusts created on or after 8-11-93 by the A/R or someone acting on behalf of the A/R, the corpus of a trust is either (1) a resource available to the A/R; or, (2) is subject to the transfer of resources penalty. Disbursements from the trust are countable income.

BASIC CONSIDERATIONS

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) applies to all trusts into which an A/R has placed his/her resources. The A/R may have established the trust for his/her own benefit, or the benefit of another person.

NOTE: Refer to Section 2338, Trust Property, for definitions pertaining to trusts and for policy on trusts created by a will. Refer to Section 2336, Trust Property – Medicaid Qualifying, for trusts created prior to 8-11-93.

Consider all trusts created by the following individuals:

- the A/R
- the A/R's spouse
- any person, including a court or administrative body, acting at the request or direction of the A/R or spouse
- any person, including a court or administrative body, with the legal authority to act on behalf of the A/R or spouse.

Consider all trusts, except those created by a will, which were created as follows:

- with the A/R's resources
  AND/OR
- with the A/R as beneficiary

Burial Trusts

A burial trust is a trust established by the A/R to pay for the funeral expenses of the A/R. A burial trust is excluded up to $5,000.00, if the A/R has not designated any funds for burial, the excess of $5,000.00, if any, is treated under the appropriate OBRA '93 provisions. An A/R can have a combination of a burial trust and funds designated for burial up to $5000.00.

BASIC CONSIDERATIONS (cont.)

The following trusts will NOT be counted or considered a transfer of assets:

- a trust containing the assets (income and resources) of an individual under age 65 who is disabled, and which is established for the sole benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court, if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the disabled individual. Any pay out could be countable income if given to the A/R. This type of trust is often referred to as a *Special Needs Trust.*

- A *Miller Trust* established in the state for the benefit of an individual if:

  - the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust), **and**
  - the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual.

NOTE: AS GEORGIA HAS A MEDICALLY NEEDY PROGRAM IN PLACE FOR NURSING FACILITY RESIDENTS, WE SHOULD NOT HAVE MILLER TRUSTS IN OUR STATE.

- A trust, generally referred to as a *Pooled Trust,* containing the assets of an individual who is disabled that meets the following conditions:

  - The trust is established and managed by a non-profit organization
  - Separate accounts are maintained for each beneficiary, even if pooled for purposes of investment and management
  - The trust was established by the disabled individual, their parents, grandparents, legal guardian or the court
  - Amounts remaining upon the beneficiary's death are paid to the State by the trust in an amount equal to the total amount of medical assistance paid on his/her behalf.

BASIC CONSIDERATIONS (cont.)

Revocable Trusts

Count the corpus or principal of a *revocable* trust as a resource available to the A/R.

Count any money generated by the trust as income to the A/R, whether or not received by the A/R.

Irrevocable Trusts

Count any portion of the corpus or principal of an *irrevocable* trust from which it is possible to make a disbursement to the A/R as a resource available to the A/R.

Count any portion of the corpus or principal of the trust from which it is NOT possible to make a disbursement to the A/R as a transfer of resources.

Count any disbursements from the trust as income to the A/R, whether or not received by the A/R.

Transfer of Resources Penalty

Consider the transfer of resources penalty, if appropriate, for any resource placed into a trust within the 60 month look back period.

The transfer of resources penalty does not apply to resources that are excluded under Non-FBR policy if transferred into a trust.

If a resource can be considered under both the OBRA '93 trust provision OR the transfer of resource penalty provision, treat the resource under OBRA '93 trust provisions.

Refer to Section 2342, Transfer of Resources, and Section 2304, Undue Hardship Provision.

PROCEDURES

Follow the steps below to determine the treatment of a trust:

Step 1 Obtain a copy of the trust document and any supporting documentation detailing any investments and distributions made by the trust.

Step 2 Determine the date that the trust was established.

- If established on or after 8-11-93, continue to step 3.
- If established prior to 8-11-93, see Section 2336, Trust Property, Medicaid Qualifying, and Section 2338, Trust Property.

Step 3 Determine if the trust is revocable or irrevocable.

Step 4 For an *irrevocable* trust, based on the conditions of the trust document, determine the following:

- the total amount of the corpus or principal considered available to the A/R. Count as a resource available to the A/R.
- the total amount to the corpus or principal considered NOT available to the A/R. Consider the transfer of resources penalty.
- the total amount of income generated by the trust. Count as income to the A/R, whether or not received by the A/R.
- any disbursements that have been made from the trust. Count as income to the A/R, whether or not received by the A/R.

Step 5 For a *revocable* trust, count the total value of the corpus or principal as a resource available to the A/R. Count any disbursements that have been made from the trust as income to the A/R, whether or not received by the A/R.

Reporting a Trust As a TPR Any trust document that contains a clause that provides reimbursement to the State in an amount equal to the total paid for medical assistance on behalf of the A/R must be reported to the Division of Medical Assistance as a third party resource. Refer to Section 2230, Third Party Resources, for complete instructions.

2338 - TRUST PROPERTY

POLICY STATEMENT

The trust principal is a resource to an individual who is legally empowered to revoke the trust and use the principal for his/her own support and maintenance.

BASIC CONSIDERATIONS

A trust is a legal arrangement by which one person holds property for the benefit of another. The person who makes the arrangement is the trustor/grantor/settlor. The person who holds the property is the trustee. The person for whom the property is held is the beneficiary.

Totten Trust

A Totten Trust is a trust in which a trust or makes himself/herself trustee of his/her own funds for the benefit of another. The trustor/trustee can revoke a Totten Trust at any time. Should the trustor/trustee die without revoking the trust, the principal of the trust reverts to the beneficiary.

If the A/R is the trustor of a Totten Trust, the principal of the trust is a resource to the A/R, and any income generated by the principal is income to the A/R.

If the A/R is the beneficiary of a Totten Trust, the principal of the trust is **not** a resource to the A/R **unless** the trust itself gives the A/R access to the property without the intervention of the trustee. When the beneficiary has no control over the trust, count as income only trust distributions actually received by the beneficiary, regardless of what the trust specifies the beneficiary should receive.

MQT

A Medicaid Qualifying Trust (MQT) is a trust created prior to 8-11-93 by an individual, spouse, or someone acting on his/her behalf, with his/her own funds, and with him/her named as the beneficiary of the trust. Refer to Section 2336, Trust Property Medicaid Qualifying.

OBRA'93

An OBRA'93 trust is a trust created on or after 8-11-93 by an individual, spouse, or someone acting on his/her behalf, with his/her own funds, and with his/her named as the beneficiary of the trust. Refer to Section 2337, Trust Property-OBRA'93.

BASIC CONSIDERATIONS (cont.)

Other Trusts

Trust property which is neither a MQT or a Totten Trust, such as a trust created by a will, will be treated as follows:

- The trust principal is not a resource to an individual who is not legally empowered to revoke the trust and use the principal for his/her own support and maintenance.

- Revocability of a trust depends on the terms of the trust agreement and/or on state law. If a trust is irrevocable, the trust principal is not anyone's resource.

- Trust earnings and disbursements are not income to the trustor or trustee unless designated as belonging to the trustor or trustee under the terms of the trust, such as fees payable to a trustee or interest payable to a trustor rather than feeding into the trust itself.

- Additions to the trust principal are not income to a trustor or trustee. However, they may be income to a trustor or trustee prior to becoming part of the trust principal. For example, if the trustor or trustee is a deemor who receives RSDI benefits and adds to the trust principal, consider the RSDI as income for deeming purposes.

- Trust earnings are not income to the beneficiary unless the trust dictates, or the trustee allows, payment to a beneficiary.

- Trust distributions are income to the beneficiary if paid to him/her in cash. They may result in income to the beneficiary if used to make certain third party vendor payments on his/her behalf.

NOTE: The transfer of assets policy can be applied whenever a trustor who is an A/R establishes a trust fund for the benefit of another person.

PROCEDURES

Review the trust document and determine whether any of the following conditions applies to the trust:

- The individual (A/R or deemor) is the trustor, trustee or beneficiary.
- The trust is revocable and, if so, whether the individual has the authority to revoke and to use the principal for his/her own support and maintenance.
- The individual has unrestricted access to the trust principal.
- The trust provides for payments to the individual or on his/her behalf.
- The trust principal generates income and, if so, whether the individual has the right to any of that income.

NOTE: If the A/R is the beneficiary of a non-MQT trust, contact the trustee to verify the actual income from the trust received by the A/R.

When trust property is a resource and its value is material to eligibility, determine the type of the property and establish its value by one of the following means:

- Contact the holder of the funds if they are in cash.
- Develop the resource value of the property as outlined in the applicable section in this chapter dealing with the specific type of property.

Record all information used in determining whether the trust is a resource or creates income. Record your conclusions and include a copy of the trust document, if any.

2339 – TRUST PROPERTY, ANNUITIES

POLICY STATEMENT

Annuities are considered trust property. An annuity that is *actuarially sound* is treated as a retirement fund. An annuity that **is not** *actuarially sound* is subject to the appropriate trust provisions.

BASIC CONSIDERATIONS

An annuity is a financial entity that provides to the purchaser the right to receive periodic payments, either for life or for a specified period of time.

An annuity is usually purchased as part of a retirement plan. Treatment of annuities is determined by whether or not the individual purchased the annuity as part of a legitimate retirement plan, or as an attempt to shelter resources for purposes of receiving Medicaid.

Using the Social Security Administration's Life Expectancy Actuarial Tables for the age and sex of the purchaser in this section, determine if the expected return from the annuity is equal to the purchase price.

- If the expected return is equal to or greater than the purchase price, the annuity is actuarially sound. Treat as a retirement fund. Refer to Section 2332, Retirement Funds to determine how to treat retirement funds.

- If the expected return is less than the purchase price, the annuity is not actuarially sound. The difference between the expected return and the purchase price is a trust. Treat under the appropriate trust provision. Refer to Sections 2336, Trust Property – Medicaid Qualifying; Section 2337, Trust roperty OBRA '93; and Section 2338, Trust Property, to determine correct treatment of trusts.

PROCEDURES

Follow the steps below to determine if an annuity is actuarially sound:

Step 1 Determine the age and sex of the purchaser at the time of purchase.

Step 2 Verify the purchase price of the annuity.

PROCEDURES (cont.)

Step 3 Determine the amount and the frequency of the payments. Determine the length of time that the individual will receive periodic payments from the annuity.

Step 4 Using the Social Security Life Expectancy Actuarial Table, determine the life expectancy of the purchaser from the date of the purchase of the annuity.

Step 5 Based on the individual's life expectancy, and the amount, frequency, and duration of the payments, calculate the total dollar amount of the payment the purchaser is expected to receive from the annuity.

Step 6 If the total dollar amount of the payment from the annuity is expected to equal or exceed the purchase price, the annuity is considered to be actuarially sound. Treat the annuity as retirement funds. See section 2332, Retirement Funds, to determine the correct treatment of retirement funds.

If the total dollar amount of payment from the annuity is expected to be less than the purchase price, the annuity is not considered to be actuarially sound. Proceed to step 7.

Step 7 Calculate the difference between the purchase price and the expected total payment from the annuity. The amount of the purchase price that the A/R is expected to receive is considered retirement funds.

Step 8 Consider the difference between the purchase price and the expected total payment (the amount of the purchase price the A/R is not expected to receive) to be a trust. Use the appropriate trust provisions (based on the date of purchase and whose funds were used) to determine how to treat the annuity. The appropriate trust provision are found in Section 2336 Trust Property – Medicaid Qualifying; Section 2337, Trust Property OBRA '93; and Section 2338, Trust Property.

Family Medicaid Refer to Section 2301, Family Medicaid Overview and to Section 2399, Treatment of Resources by Resource Type Chart.

LIFE EXPECTANCY TABLE – MALES

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	71.80	24	49.55	48	28.02
1	71.53	25	48.63	49	27.17
2	70.58	26	47.72	50	26.32
3	69.62	27	46.80	51	25.48
4	68.65	28	45.88	52	24.65
5	67.67	29	44.97	53	23.82
6	66.69	30	44.06	54	23.01
7	65.71	31	43.15	55	22.21
8	64.73	32	42.24	56	21.43
9	63.74	33	41.33	57	20.66
10	62.75	34	40.23	58	19.90
11	61.76	35	39.52	59	19.15
12	60.78	36	38.62	60	18.42
13	59.79	37	37.73	61	17.70
14	58.82	38	36.83	62	16.99
15	57.85	39	35.94	63	16.30
16	56.91	40	35.05	64	15.62
17	55.97	41	34.15	65	14.96
18	55.05	42	33.26	66	14.32
19	54.13	43	32.37	67	13.70
20	53.21	44	31.49	68	13.09
21	52.29	45	30.61	69	12.50
22	51.38	46	29.74	70	11.92
23	50.46	47	28.88	71	11.35

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
72	10.80	88	4.34	104	1.78
73	10.27	89	4.09	105	1.68
74	9.27	90	3.86	106	1.59
75	9.24	91	3.64	107	1.50
76	8.76	92	3.43	108	1.41
77	8.29	93	3.24	109	1.33
78	7.83	94	3.06	110	1.25
79	7.40	95	2.90	111	1.17
80	6.98	96	2.74	112	1.10
81	6.59	97	2.60	113	1.02
82	6.21	98	2.47	114	0.96
83	5.85	99	2.34	115	0.89
84	5.51	100	2.22	116	0.83
85	5.19	101	2.11	117	0.77
86	4.89	102	1.99	118	0.71
87	4.61	103	1.89	119	0.66

LIFE EXPECTANCE TABLE – FEMALES

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	78.79	25	54.98	50	31.37
1	78.42	26	54.02	51	30.48
2	77.48	27	53.05	52	29.60
3	76.51	28	52.08	53	28.72
4	75.54	29	51.12	54	27.86
5	74.56	30	50.15	55	27.00
6	73.57	31	49.19	56	26.15
7	72.59	32	48.23	57	25.31
8	71.60	33	47.27	58	24.48
9	70.61	34	46.31	59	23.67
10	69.62	35	45.35	60	22.86
11	68.63	36	44.40	61	22.06
12	67.64	37	43.45	62	21.27
13	66.65	38	42.50	63	20.49
14	65.67	39	41.55	64	19.72
15	64.68	40	40.61	65	18.96
16	63.71	41	39.66	66	18.21
17	62.74	42	38.72	67	17.48
18	61.77	43	37.78	68	16.76
19	60.80	44	36.85	69	16.04
20	59.83	45	35.92	70	15.35
21	58.86	46	35.00	71	14.66
22	57.89	47	34.08	72	13.99
23	56.92	48	33.17	73	13.33
24	55.95	49	32.27	74	12.68

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
75	12.05	90	4.71	105	1.81
76	11.43	91	4.40	106	1.69
77	10.83	92	4.11	107	1.58
78	10.24	93	3.84	108	1.48
79	9.67	94	3.59	109	1.38
80	9.11	95	3.36	110	1.28
81	8.58	96	3.16	111	1.19
82	8.06	97	2.97	112	1.10
83	7.56	98	2.80	113	1.02
84	7.08	99	2.64	114	0.96
85	6.63	100	2.48	115	0.89
86	6.20	101	2.34	116	0.83
87	5.79	102	2.20	117	0.77
88	5.41	103	2.06	118	0.71
89	5.05	104	1.93	119	0.66

2340 – UNIFORM GIFTS TO MINORS

POLICY STATEMENT

If an A/R is the donor of a uniform gift to a minor (UGM), the transfer of resources provision may apply.

If an A/R is the recipient of a UGM, the UGM is not a countable resource until the month after the A/R's 21st birthday.

BASIC CONSIDERATIONS

A UGM involves the following:

- The donor, who makes an irrevocable gift of money or other property (assets) to a minor.
- The recipient, who automatically receives control of the assets upon attainment of majority (age 21).
- The gift, plus any earnings it generates, which is under the control of a custodian until the recipient reaches the age of majority established by state law.
- The custodian, who has full discretion to spend for the minor's support, maintenance, benefit or education as much of the assets as s/he deems necessary.

Since a custodian of UGM assets cannot legally use any of the funds for his or her own personal benefit, the UGM assets are not a resource to the custodian.

NOTE: Additions to or earnings on the UGM principal are not income to the custodian since s/he has no right to use them for his/her own support and maintenance. Additions to the principal may be income to the donor prior to becoming part of the UGM principal.

NOTE: The custodian's UGM disbursements to the minor, including third party vendor payments for food, clothing, or shelter, are income to the minor.

When the recipient reaches majority age, all UGM property becomes subject to evaluation as income in the month of attainment of majority.

PROCEDURES

Verify all allegations of the existence of a UGM by obtaining a copy of the document of ownership, such as a deed, certificate of deposit, savings passbook or other written document from the issuing source (donor) designating a gift under UGM. Unless there is evidence to the contrary, accept any such document as proof of a valid gift.

If there is no document designating a UGM, do not develop further. Deal with the property as if there had been no allegation of a UGM.

Contact the State Medicaid Unit for further assistance.

2341 – VICTIMS' COMPENSATION

POLICY STATEMENT	Unspent portions of Victims' Compensation are excluded as resources for nine full calendar months after the month of receipt. This is an excluded resource for Family Medicaid.
BASIC CONSIDERATIONS	Victims' Compensation (VC) is payments from a fund established by a state for expenses incurred or losses suffered as a result of a crime. Interest earned on unspent VC is *not* excluded from income or resources.
PROCEDURES	If an individual alleges that his or her resources include unspent VC, ask the individual to submit evidence that establishes the following: • the source, date(s), and amount(s) of VC payments(s) • the VC was paid as compensation for expenses incurred or losses suffered as the result of a crime. Obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the VC payment(s). Assist the individual as necessary. Accept the following as evidence establishing that the payment was a VC payment: • a letter or check stub from the payment indicating the payment is VC • a subsequent letter requested by the claimant/recipient to clarify that the reason for the payment is VC. • Any other document indicating the reason for the payments as VC. If the individual is unable to submit acceptable evidence, attempt to obtain the needed information over the phone through a contact with the agency that issued the VC.

2342-TRANSFER OF RESOURCES

POLICY STATEMENT

If an A/R, anyone acting legally on an A/R's behalf, anyone holding an asset in common with an A/R, or the A/R's spouse, gives away or sells resources for less than current market value (CMV) during the look-back period, the A/R may be subject to a transfer of resource penalty.

The transfer of resource policy does not apply to Family Medicaid.

BASIC CONSIDERATIONS

Definitions

TEFRA Tax Equity and Fiscal Responsibility Act of 1982 - the legislative basis for the transfer of resource penalty prior to 7/1/88.

MCCA Medicare Catastrophic Care Act of 1988 - the legislative basis for the transfer of resource penalty between 7/1/88 and 10/1/93.

OBRA'93 Omnibus Budget Reconciliation Act of 1993 - the legislative basis for the transfer of resource penalty, effective 10/1/93, for all resources transferred on or after 8/11/93.

Uncompensated Value The difference between the FMV of the resource at the time of the transfer and compensation received for the resource.

Look Back Period A specified number of months immediately preceding the application or request for assistance for which the worker must determine if a resource has been transferred. The look back period is different for each type of penalty:

TEFRA-24 months, beginning with the month of application;

MCCA-30 months, beginning with the month of application

OBRA'93

-60 months for resources transferred into a trust, beginning with the first month the A/R enters LA-D and requests Medicaid benefits to pay the cost of care;

-36 months for other transferred resources beginning with the first month the A/R enters LA-D and requests Medicaid benefits to pay the cost of care.

BASIC CONSIDERATIONS (cont.)

All Transfers

A transfer of resources penalty does **not** apply if any one of the following conditions is met:

- A resource is used to pay a valid debt.
- A resource is a valid loan.
- An A/R transfers a resource to his/her spouse, or to another individual for the sole benefit of the spouse. See page 2502 for a definition of *sole benefit of.*
- An A/R can provide a satisfactory showing that he/she intended to dispose of the resource for fair market value, or for other valuable considerations. This would include situations where an individual is defrauded or executes a transfer as a result of misrepresentation.
- The transferred resources have been returned to the individual.
- Denial of eligibility would cause an undue hardship. Undue hardship must be considered in every case. Refer to Section 2304.
- A resource was transferred exclusively for a purpose other than to qualify for Medicaid.
- A resource owned by the community spouse of an institutionalized A/R is transferred by the community spouse after eligibility has been established.

Transfers Made Prior to 8-11-93 (MCCA)

- A resource was excluded at the time of the transfer, such as a homeplace.
- An ineligible spouse or parent transfers his/her own resource to someone other than the A/R.
- A co-owner of an unrestricted bank account jointly owned by the A/R withdraws funds from the account without the A/R's signature.
- An applicant transferred a resource more than 30 months prior to the month of application.

BASIC CONSIDERATIONS (cont.)

Transfers Made On Or After 8/11/93 (OBRA'93)

A transfer of resources penalty does **not** apply if any one of the following conditions is met:

- The homeplace was transferred (1) to the spouse of the A/R or (2) child of the A/R if the child is under the age of 21 or is blind or is permanently and totally disabled.
- The homeplace was transferred to a sibling of a LA-D A/R if the sibling has an equity interest in the home and has been residing in the home for at least one year immediately prior to the A/R entering LA-D.
- The homeplace was transferred to a son or daughter of the A/R who has been residing in the home for at least two years immediately prior to the A/R entering LA-D, and the son or daughter was providing such care to the A/R as to permit the A/R to continue to reside at home rather than enter LA-D.
- The assets were transferred to a trust established for the sole benefit of (1) the A/R's disabled child or (2) a disabled individual who is under 65 years of age. Use the same definition of sole benefit of as for transfer to a spouse. See Section 2502.
- The transferred resource was any resource other than a homeplace that can be excluded under FBR policy.
- The resource was excluded under Non-FBR policy and was transferred into a trust.

A transfer penalty **does** apply and is developed if any one of the following conditions is met:

Transfers Made Prior to 8/11/93 (MCCA)

- An applicant gives away or sells a non-excluded resource for less than CMV or refuses an inheritance during the 30 month period.

Transfers Made On or After 8/11/93 (OBRA '93)

- The spouse of an A/R transfers an asset to anyone for purposes other than the sole benefit of him/herself during the 36 month look back period. Refer to Section 2502 for definition of *sole benefit of.*

BASIC CONSIDERATIONS

Transfers Made on Or After 8/11/93 (OBRA '93) (cont.)

- An A/R gives away or sells a resource for less than CMV, or refuses an inheritance, during the 36 month look back period or anytime thereafter.
- An A/R transfers non-excluded resources into a trust during the 60 month look back period or anytime thereafter.
- An A/R transfers homeplace property to anyone other than those individuals listed in the above exceptions.
- An asset is held by an A/R in common with another individual as joint tenant, tenancy in common or similar arrangement and other owner reduces or eliminates the A/R's ownership or control. NOTE: It does not matter if the A/R had knowledge or gave consent. This includes withdrawals from joint accounts by the other account holder.

The possibility of a transfer of resource must be documented on every application for ABD Medicaid, with detailed development at the time of application for a LA-D COA.

Indications that a transfer of ownership may have occurred include, but are not limited to the following:

- an individual alleges a resource transfer
- an individual's resources exceed the statutory limit for one or more months of the review period and decline in subsequent months
- other evidence, such as an IRS alert indicating the sale of land or stock.

PROCEDURES

Developing the Possibility of a Transfer of Resources

Obtain the individual's signed statement on the following:

- the nature of the transfer-whether the resource was sold, given away, exchanged for goods or services, etc.
- the method of transfer-whether the property was listed with an agent and sold, transferred without financial considerations, disposed of through purchase(s), etc.
- the date of transfer
- a description of the transferred property
- the market value of the transfer - the amount of cash transferred or the estimated current market value(CMV) minus encumbrances of the property the month of transfer

BASIC CONSIDERATIONS

Developing the Possibility of a Transfer of Resources (cont.)

- the amount of compensation received, if any-whether there were proceeds, their value and whether additional consideration is expected and when
- any remaining ownership interest, such as a partial interest.

Obtain a copy of available evidence of the alleged transaction. This would include items such as bills of sale, statements of purchase, receipts from landlords for prepayment of rent or corroborating statements from recipients of gifts.

NOTE: Recognize that an individual may not be able to provide an exact to the penny accounting for purchases incurred more than a month or two in the past. Additionally, an individual may allege a purchase or that money was spent in a way, which cannot be corroborated, such as gambling. Exercise great care in resolving the issue of transfer by spending. Any reasonable accounting can be accepted.

Limit development when an individual alleges having transferred excess countable resources through spending, such as making one or more purchases. Such allegations must always be documented by the individual's statement, but no other evidence need be developed except in either of the following situations:

- The individual cannot provide enough information about the alleged purchases to establish his/her resource eligibility status as of the first moment of each relevant month.
- Information in the files makes the allegations questionable.

If an A/R is found to have incurred a transfer of resources penalty, complete the following procedures:

- Compute and document the correct penalty.
- Notify the A/R that the penalty is being imposed, and that the undue hardship provision was considered and determined not to be applicable.
- Schedule an alert on the system, such as "transfer of resources penalty in effect through MM/YY".
- For all cases involving a penalty of more than three years, flag the record as an exception to record retention procedures. Do not destroy the record until the penalty expires or the individual dies, whichever occurs first.

PROCEDURES (cont.)

Medicaid Catastrophic Care Act (MCCA) Transfer of Resources Penalty

Develop a MCCA transfer of resources penalty on all Medicaid Applications effective 7/1/88 who have transferred a non-excluded resource for less than CMV within the 30 month look back period but prior to August 11, 1993.

Impose a transfer penalty only on applicants requesting a nursing home vendor payment or community waivered services, including current SSI recipients and SSI recipients changing to ABD Medicaid:

- Do not authorize a vendor payment for nursing home residents.
- Do not approve cost share for CCSP recipients. Return Form 5599 to the CCSP case manager with a notation that the A/R is not eligible for waivered services due to a penalty.

Determine the number of months of the penalty by dividing the total uncompensated value (UV) of the transferred resource by the average monthly private pay rate of the nursing home in which the A/R resides (daily rate X 365/12). For community waivered services penalty computations, compute the penalty using the private pay rate of the nursing home of the A/R's choice.

Do not impose a penalty for a fraction of a month. Round down all computations.

Impose the transfer penalty to begin with the month following the month of transfer, not to exceed 30 months.

OBRA '93 Transfer of Resources Penalty

Develop an OBRA '93 transfer of resource penalty on every A/R effective October 1, 1993. Develop a penalty on all resources transferred within the 36 month look back period or anytime thereafter. Impose an OBRA '93 penalty only on those resources transferred on or after 8/11/93. For any resource transferred prior to 8/11/93, apply the MCCA penalty.

Determine the number of months of the penalty by dividing the total uncompensated value (UV) of the transferred resource by the average Georgia private pay rate (See Appendix A.1). Drop all fractions.

Begin the penalty the month that the resource was transferred. Do not apply a penalty for a fraction of a month. There is no limit to the number of months a penalty may last.

PROCEDURES

OBRA '93 Transfer of Resource Penalty (cont.)

Impose the penalty on A/R's in LA-D as follows:

- A/R's requesting nursing home service will not be eligible for a vendor payment. Determine eligibility as usual. Do not authorize a vendor payment. The A/R is responsible for paying the private pay rate to the NH.
- A/R's requesting services under a home and community based waiver (CCSP, ICWP, MRWP/CHSS, Hospice, Deeming Waiver) will be ineligible for home and community based services (not receiving waivered services). Do not determine eligibility under the Medicaid CAP. Complete a CMD.

All Transfers

When it is determined that a resource transfer will result in a penalty period, notify the A/R, PR and nursing home via the system generated notice. The notice should include a statement that the hardship provision was determined not to be applicable. For CCSP, ICWP, MRWP/CHSS and Hospice COA's, return the communicator form to the originator notated with the month the penalty period will end.

SPECIAL CONSIDERATIONS

If an individual makes more than one application for Medicaid (whether approved or denied), the look back period is based on the *first* date that the individual enters LA-D and requests Medicaid to pay for those services.

If an A/R is not in a nursing home or receiving community waivered services at the time the transfer penalty is computed, the penalty has no immediate effect. However, if the A/R enters a NH or begins receiving community waivered services before the penalty expires, impose the remainder of the penalty.

If a resource is transferred back to the A/R, void the penalty. Determine eligibility for all requested months as if no transfer had ever occurred.

If a resource is partially transferred back to the A/R, recompute the penalty. An A/R may not exchange non-excluded resources for services received prior to the transfer unless there was a written contract.

Transfers Before 7/01/88

If a transfer of resources is discovered that occurred before 7/01/88, a penalty other than the MCCA penalty may be appropriate, including a penalty resulting in ineligibility for Medicaid for a certain number of months. Consult your supervisor for correct procedures to follow if this situation occurs.

SPECIAL CONSIDERATIONS (cont.)

Multiple Transfers Prior to 8/11/93 (MCCA)

For an A/R who transfers more than one resource, develop a transfer of resources penalty on each separate transfer. Begin the penalty with the earliest transfer and impose the penalties concurrently.

Multiple Transfers On or After 8/11/93 (OBRA '93)

For an A/R who transfers more than one resource, develop a transfer of resources penalty on each separate transfer. Impose all penalties consecutively.

- Begin the penalty with the first transfer.
- Impose the penalty for the second transfer to begin the month following the expiration of the first penalty.
- Impose the penalty for the third transfer to begin the month following the expiration of the second penalty.
- Continue the process as necessary for additional transfers.

Treatment of Income As a Resource

When it is determined that an A/R disposes of income that would be a resource the next month (e.g., a lump sum payment) for reasons other than ordinary and legitimate expenses, develop a transfer of resources penalty. If the A/R gives away or assigns the right to receive recurring income, develop a transfer of resources penalty. All the policies and procedures for OBRA '93 transfer of resources apply to a transfer of income.

- If the income is a lump sum, determine a penalty based on the value of the lump sum minus ordinary and legitimate expenses.
- If the A/R assigns or gives away recurring income, determine a penalty for each income payment given away. Do not impose a penalty for a fraction of a month.

OBRA '93 TRANSFER POLICY FOR APPLICANTS/RECIPIENTS
(Effective 8/11/93)

Step 1 Subtract the compensation received from the CMV of the transferred resource.

a._____ value of transferred resource

b.-_____ compensation received

c. _____ uncompensated value (enter on line 2.a)

Step 2 Compute penalty.

a._____ (1.c) divided by _____(NH PP BR*) = _____months penalty**

*NH PP BR (Nursing Home private pay billing rate): the average Georgia private pay rate. Refer to Appendix A.1.

The number of months the A/R is ineligible for a nursing home vendor payment. Medicaid eligibility is not affected for NH A/Rs. However, do **not approve eligibility for CCSP, ICWP, MRWP/CHSS, Hospice or Deeming Waiver COAs until the penalty period expires.

The penalty begins the month in which the transfer occurred. There is **NO** limit to the number of months a penalty may last.

MCCA UNCOMPENSATED VALUE DETERMINATION

Computing the Uncompensated Value of a Transferred Resource

Follow the steps below to determine the uncompensated value (UV) of a transferred resource for use in applying a transfer of resources penalty.

Step 1 Subtract the value of countable resources (excluding the transferred resource) from the appropriate resource limit.

- For applicants, use the value of resources in the month of application.
- For recipients, use the value of the resources in the month of discovery.

a. _____ current resource limit (individual/couple)

b. -_____value of resources

c. _____ amount of additional resources A/R could have owned and been eligible (enter on 3.b)

Step 2 Subtract the compensation received from the CMV of the Transferred resource.

a. _____ value of transferred resource

b. -_____ compensation received

c. _____ uncompensated value (enter on 3.a)

Step 3 Subtract the result of Step 1(c) from the result of Step 2(c). This is the amount used to compute the penalty.

a. _____ uncompensated value (2.c)

b. -_____ resource limit less current resources (1.c)

c. _____ amount used to compute penalty

NOTE: If an A/R has transferred more than one resource, develop a penalty for each transfer. Complete step 1 for only the first transfer.

2343 - GERMAN REPARATION PAYMENTS

POLICY STATEMENT	Unspent German Reparation Payments are permanently excluded resources.
BASIC CONSIDERATIONS	Interest earned by German Reparations Payments conserved in a financial account is not excluded from income by this provision.
PROCEDURES	If an individual alleges that his or her resources include German reparations payments, obtain a statement from the individual on the following: • the date(s) and amount(s) of such payment(s) • the date(s) and amount(s) of any corresponding account deposit(s) Accept the allegation absent evidence to the contrary.

2399 – TREATMENT OF RESOURCES BY RESOURCE TYPE

The chart below lists resources alphabetically and provides the following information

- description of the resource
- whether the resource is liquid or non-liquid
- the value to consider: cash value (CV), equity value (EV) or fair market value (FMV)
- whether the resource is included (I) or excluded (E) in the eligibility determination.

NOTE: When the resource is excluded, the liquid/non-liquid indication may be omitted in the chart below.

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
ACTION/DOMESTIC VOLUNTEER PROGRAMS (Unspent)	Refer to Chart 2399.3 in this section.	E	FBR – E NON-FBR – E
AGENT ORANGE PAYMENTS Liquid	Payments made to Vietnam Veterans who were exposed to Agent Orange and to surviving spouses and children of deceased Vietnam Veterans who were exposed to Agent Orange. Refer to Chart 2399.2 in this section.	E	FBR – E NON-FBR – E
ANNUITIES (Supplemental Retirement Plans) Liquid	An investment plan. It can be established as a supplemental retirement plan through an insurance company or other investment source. **EXCEPTION:** Exclude if termination of employment or retirement is required for access and employment continues. **NOTE:** If recurring payments are made from the annuity, refer to Chart 2499.1, Types of Income in Medicaid, and Section 2339.	I	FBR AND NON-FBR Treat as Retirement Funds if actuarially sound. Refer to sections 2332 and 2339. Treat as a Trust if not actuarially sound. Refer to sections 2336, 2337, 2338, and 2339.
AUSTRIAN SOCIAL INSURANCE (unspent)	Refer to Chart 2399.2 in this section.	E	FBR – Exclude If Based On Wage Credits. Refer to Chart 2399.2. NON-FBR – SAME

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
BONDS • municipal • corporate • government • U.S. Savings Liquid	Government-issued interest-bearing certificates redeemable on a specific date, such as U.S. savings bonds, municipal, corporate, government bonds, etc. CMV is a countable resource.	I	FBR – I NON-FBR – I
BURIAL CONTRACTS/ BURIAL SPACE ITEMS	Prepaid contracts to cover funeral expenses For ABD Medicaid, refer to section 2311. * For Family Medicaid, exclude up to $1500 of the combined EV of all burial contracts and burial insurance for each AU or BG member	*	FBR – Exclude burial space items owned outright or if itemized in a paid up burial contract designated for the A/R or an immediate family member. NON-FBR – Totally exclude ***any*** burial contracts if designated for the A/R, spouse or deemor.
BURIAL FUNDS	Funds that have been set aside for burial. For ABD refer to Section 2312.	There is no burial exclusion in Family Medicaid.	FBR – Exclude up to $1500 each for A/R and their spouse minus CMV of irrevocable burial contracts and FV of excluded life and burial insurance policies. The designated burial fund must be a liquid resource and cannot be commingled with non-burial resources. Refer to section 2312, Burial Funds. NON-FBR – Exclude up to $5000 each for A/R and their spouse.

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
BURIAL FUNDS (cont.)			The resources designated as a burial fund may be *any* resource and may be commingled with non burial resources. Refer to Section 2312, Burial Funds.
BURIAL PLOTS Non-liquid	One burial plot per AU or BG member Use EV for each additional plot and count toward the resource limit.	E	FBR – Refer to Section 2311. NON-FBR – Exclude all burial plots owned outright by an A/R or deemor.
CASH Liquid	Money held by an AU or BG member that has not been considered as income for that month. Use CV	I	FBR – I NON-FBR – I
CERTIFICATE OF DEPOSIT Liquid	Certificate that states that the named person(s) has a specific sum on deposit which accrues interest over a set period of time less any penalties for early withdrawal. Use CV.	I	FBR – I NON-FBR – I
CHECKING ACCOUNTS Liquid	An account on which checks may be written against amounts on deposit. Use CV less any money considered income in that month. **EXCEPTION:** Refer to the section on Jointly Owned Bank Accounts, if a resource is jointly owned or ownership is disputed.	I	FBR – I NON-FBR – I
COIN COLLECTIONS Liquid	A collection of coins, regardless of age. Use the face value of the coin collection as the cash value.	I	FBR – I NON-FBR – I

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
COMMINGLED FUNDS	Excluded resources commingled with countable resources **NOTE:** The portion of the commingled funds that can be identified as excluded resources retain the exclusion. Funds that cannot be identified as excluded resources must be counted in their entirety.	I	FBR – I NON-FBR – I
CONTRACTS – PROMISSORY NOTES LOANS AND PROPERTY AGREEMENTS	Refer to Section 2313 for the definition of each.	N/A	FBR – Consider a countable resource if there is ***an offer to buy***. Count higher of 2 offers. Exclude if there is ***no offer to buy.*** NON-FBR – Exclude if payments are being made. **NOTE:** Count any payments as income.
CREDIT UNION ACCOUNTS Liquid	Money on deposit with a cooperative organization with the functions of a bank (loans money, provides checking & savings account services, etc.) Use CV less any money considered income in that month.	I	FBR – I NON-FBR – I
DEFERRED COMPENSATION PLANS Liquid	Tax deferred income in a fund available only upon termination of employment, hardship or retirement Use CV of any withdrawals from plan. Withdrawals would be counted in both ABD and Family Medicaid as income.	E	FBR – E NON-FBR – E
DEATH BENEFITS (unspent)	Money in excess of last illness and funeral expenses.	E	FBR – May be able to exclude temporarily. Refer to Chart 2399.2. NON-FBR - SAME

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
DISASTER RELIEF ACT OF 1974 AND EMERGENCY ASSISTANCE ACT OF 1988	Any governmental (federal, state, local) payments, which are designated for the restoration of a home, damaged in a major disaster or natural catastrophe. This includes governmental payments to save lives, protect property and public health and safety or to lessen or avert the threat of a catastrophe or major disaster.	E	FBR – Exclude Permanently NON-FBR – SAME
Liquid	Includes loans and grants from the Federal Emergency Management Assistance (FEMA). Includes payments made by the Department of Housing and Urban Development, disaster loans, family grant programs and grants made by the Small Business Administration as a result of disasters.		
DIVIDENDS LEFT TO ACCRUE ON:	Accrued dividends earned on financial investments, such as stocks, are resources separate and apart from the investment source.		
INVESTMENTS		E	FBR – I NON-FBR – I
LIFE INSURANCE		E	FBR – Countable resources on all policies, including term and excluded policies separate and apart from CSV. NON-FBR – Exclude on all policies.
EARNED INCOME TAX CREDIT (EITC)	Tax credit that is received in one of the following ways:		
	• Advance payments – tax credits received as part of the regular pay check	E	FBR – N/A NON-FBR – SAME
	• Non-recurring lump sum – tax credits received in the form of an income tax refund	E	FBR – N/A NON-FBR – SAME
EDUCATION ASSISTANCE (unspent)	Unspent portion of payments for education assistance which is excluded as a resource.	E	FBR – Exclude portions for tuition fees and other necessary expenses NON-FBR – SAME

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
ENERGY ASSISTANCE OTHER THAN LIHEAA	Payments or allowances made under any federal, state, or local law for the purpose of energy assistance.	E	FBR – E
Liquid	Federal or State one-time assistance for weatherization or emergency repair or replacement of heating or cooling devices. Energy Assistance payments made under state law.	E	NON-FBR – E
EQUIPMENT	Tools, machinery, stock and inventory essential to the production of goods or services, even during temporary periods of unemployment or inactivity. Annually produces income consistent with FMV, even if only used on a seasonal basis. Contact local realtors, local tax assessors, small business administration, etc to determine prevailing rate of return.	E	FBR – E NON-FBR – E
GERMAN REPARATION (unspent)	Unspent German Reparation payments are permanently resources.	E	E
HOMEPLACE Non-liquid	The home and surrounding land occupied by the AU or A/R, if not separated by intervening property owned by others.	E Refer to Section 2317, Family Medicaid Homeplace.	FBR – E NON-FBR – E Refer to Section 2316, ABD Homeplace, if the A/R is absent from a homeplace located in another state.
HOME REPLACEMENT FUNDS (unspent)	Proceeds from the sale of a home.	E* *Exclude for up to 6 months.	FBR – Exclude for up to 3 months if A/R signs a statement of intent to buy a new homeplace. Refer to Chart 2399.2. NON-FBR – SAME

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
HOUSEHOLD/ PERSONAL GOODS Non-liquid	Household and personal effects or other belongings such as furniture, appliances, clothing, personal items or items required because of a disability	E	FBR – Exclude the following: • One wedding ring per A/R/deemor • One engagement ring per A/R/deemor • Items required for medical reasons, AND • $2,000 of the equity value of all other household goods and personal effects NON-FBR – All excluded
HOUSEHOLD ITEMS OF UNUSUAL VALUE Non-liquid	Items such as expensive silver, jewelry, stamps, guns, or other such collections.	E	See Household/Personal Goods and Refer to Section 2319
INCOME TAX REFUND	Monetary refunds paid to taxpayers from the state or federal government Count the total amount of the refund if the refund is for a single individual. If the refund is a joint check for a jointly filed tax return, see Jointly Owned Resources in Section 2301 for Family Medicaid and Section 2304 for ABD Medicaid If any portion of the refund includes EITC, refer to Earned Income Tax Credit (EITC) in this section.	I	FBR - E NON-FBR - E
INDIAN/ALASKAN NATIVE PAYMENTS Liquid	Payments to native Americans based on federal statutes Examples of these statutes include, but are not limited to, the following: • Alaska Native Claims Settlement Act • Sac and Fox Indian claims • Indian Tribal Payments under PL 94-114, Section 6	E	FBR - E NON-FBR - E

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
INDIAN/ALASKAN NATIVE PAYMENTS (cont.)	• Grand River Band of Ottawa Tribal payments under PL 94-540 • Public Law to the Confederated Tribes and Bands of the Yakima Indian and Apache Tribe of the Mescalero • Payments made under the Maine Indian Claims Settlement Act of 1980 • Navajo or Hopi Indian pursuant to PL 93-531 • Indian Child Welfare, Public Law 95-608		
INDIVIDUAL DEVELOPMENT ACCOUNT (IDA) Liquid	An account established by or on behalf of a TANF A/R for post-secondary educational expenses, first purchase of a home or to start a new business. Exclude funds up to $5000, including funds withdrawn and used for the stated purpose. At the point the owner of the IDA is no longer a TANF recipient, the IDA becomes a countable resource in the FS and Medicaid programs.	E I	FBR - E NON-FBR - E
INHERITANCES AND UNPROBATED ESTATES AND WILLS	An ownership interest in an unprobated estate may be a resource.	Refer to Section 2320.	FBR - Refer to Section 2320. NON-FBR - SAME
INSTALLMENT CONTRACTS/ AGREEMENTS (for sale of land or buildings) Non-liquid	A written agreement with specific stipulations for the sale of land or buildings and the contract/agreement produces income consistent with its FMV **NOTE:** The property sold under the contract, or held as security in exchange for a purchase price consistent with the FMV of the property is also excluded.	E	FBR - E NON-FBR - E
JAPANESE/ALEUTIAN RESTITUTION	Restitution payments made by the U.S. Government to Japanese-Americans and Aleutians or their survivors who were interned or relocated during WWII.	E	FBR-Exclude Permanently NON-FBR - SAME

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
KEOGH PLAN (owned by individual) Liquid	A retirement plan Consider the total CV of the funds in the retirement plan, minus the early withdrawal penalty. **NOTE:** If the plan is owned by more than one person, refer to Jointly Owned Resources in Section 2301 for Family Medicaid and Section 2302 for ABD Medicaid.	I	FBR - I NON-FBR - I
KEOGH PLAN (owned with others) Liquid	If the plan contains a contractual agreement with an individual whose resources will not be considered in determining eligibility, the funds are considered inaccessible to the AU.	E	Refer to Sections 2332 and 2334
LIFE INSURANCE Liquid	Insurance policy which pays a beneficiary on the death of an individual	E	FBR - Exclude CSV only if combined FV's of ***all*** policies is $1500 or less. Count accrued dividends on ***all*** policies. NON-FBR - Exclude CSV of ***each*** policy with a FV of $5000 or less. Exclude accrued dividends on ***all*** policies.
LIFE INTEREST/LIFE ESTATE AND REMAINDER INTEREST Non-liquid	Property that an individual has a right to use but not dispose of during his/her life. Consider any income received from the property.	E	FBR - I NON-FBR - Exclude life estates, count remainder interests. Refer to Section 2322
LIVESTOCK/PETS	Animals owned for the following purposes: • Raised solely for purposes of feeding AU members • Producing income that is consistent with its FMV • Used to assist a disabled individual.	E	FBR - E NON-FBR - E

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
LIVESTOCK/PETS (cont.) Non-liquid	• Not producing income consistent with FMV • Used for recreational purposes and no income is derived. Count EV.	I	FBR - I NON-FBR - E
LOANS FROM OTHERS Liquid	Money received by the AU or A/R that the AU or A/R has an obligation to repay * Considered income and not a resource.	E	E
LOANS TO OTHERS (NOTES RECEIVABLE)	Monies loaned to persons outside the AU where a repayment agreement exists Count CV of any money owed to the AU.	I	I* *Refer to Section 2313 for development of countable income for FBR and Non-FBR cases.
LOW INCOME HOME ENERGY ASSISTANCE ACT LIHEAA Liquid	Payments for home energy provided to, or indirectly on behalf, of an AU.	E	FBR - E NON-FBR - E
LUMP SUMS Liquid	Money received in the form of a lump sum that is not expected to recur, i.e. rebates, retroactive or corrective payments for prior months, insurance settlements, federal or state tax refunds.	Refer to the Chapter on Income for treatment in Family Medicaid	FBR - Refer to Chart 2399.2. NON-FBR - SAME
LUMP SUM/SSI BACK PAYMENTS Liquid	Payments for previous SSI benefits owed and paid to an individual who is currently receiving SSI. Payment for previous SSI benefits owed and paid to an individual who is no longer receiving SSI ***Family Medicaid:** Disregard as income /resource in the month of receipt and any remainder in the month after receipt. Any remainder after these two months is counted as a resource.	*	Refer to Section 2334 for ABD Medicaid.

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
NON-HOMEPLACE, REAL PROPERTY	Buildings and lands which are owned by the AU and not considered part of the homeplace.	I	FBR - Count Equity value unless successfully rebutted or partially or totally excluded due to the following: • Essential to self support • Undue hardship to co-owner • Bona fide effort to sell • Undue Hardship provision NON-FBR - SAME
NON-LIQUID RESOURCES FOR WHICH A BONA FIDE EFFORT TO SELL IS BEING MADE		E	FBR - E NON-FBR - E
PASS ACCOUNT (Plan to Achieve Self-Sufficiency) Liquid	Money deposited in a bank account to be used for a SSI individual in a plan for self-sufficiency approved by the SSA **NOTE:** The interest earned from a PASS account is disregarded as income.	E	FBR - E NON-FBR - E
PATIENT FUND ACCOUNTS	Funds held by a nursing home for their residents	N/A	FBR - N/A NON-FBR - I
PENSION PLAN (including 401K plans) Liquid	A retirement plan provided by an employer Exclude as inaccessible if still employed under the plan. For ABD Medicaid, exclude if termination of employment is required in order to receive benefits. If funds are withdrawn, consider the cash value.	E I	FBR - Exclude if receiving periodic payments. Otherwise, count as a resource. Exclude accounts owned by a ineligible spouse, parent or spouse of parent. Refer to Section 2332. NON-FBR - SAME N/A

Chart 2399.1 – Types of Resources			
SOURCE/TYPE	**DESCRIPTION/VALUE TO CONSIDER**	**FAMILY MEDICAID**	**ABD MEDICAID FBR/NON-FBR**
PERSONAL PROPERTY-equipment, tools, machinery, stock and inventory essential to the production of goods or services, even during temporary periods of unemployment or inactivity Liquid	If annually produces income consistent with FMV, even if only used on seasonal basis Contact local tax assessors, small business administration, etc. to determine prevailing rate of return. If essential to employment or self employment of an AU member **NOTE:** Value retains exclusion for one year from date the AU member terminates self-employment from farming. Does not produce income consistent with FMV or is not essential to employment or self-employment Consider the equity value.	E E I	E E I
PREPAYMENTS AND DEPOSITS (NH)	Made on behalf of a person who enters a nursing home and refunded when approved for Medicaid.	N/A	FBR - N/A NON-FBR - I (unless refund is made to someone other than the A/R)
PROPERTY ESSENTIAL TO SELF-SUPPORT	• Business • Goods/Service for Home Consumption • Non-Business Income Producing	E	FBR - Exclude up to $6000 of EV if net earnings are at least 6% of the amount being excluded as a resource NON-FBR - Exclude regardless of rate of return or loss
PUBLIC LAW 103-286 Liquid	Payments to individuals received as a result of their status as victims of Nazi persecution	E	E
RELOCATION ASSISTANCE (unspent)	Refer to Section 2330.	E	FBR - Exclude up to 9 months (exclusion ends 5/94) NON-FBR - SAME

Chart 2399.1 – Types of Resources			
SOURCE/TYPE	**DESCRIPTION/VALUE TO CONSIDER**	**FAMILY MEDICAID**	**ABD MEDICAID FBR/NON-FBR**
REPAIR/REPLACEMENT FUNDS	Refer to Section 2331.	E	FBR - Exclude up to 18 months. Refer to Charts 2399.2 and 2399.3. NON-FBR - SAME)
RESOURCES OF A SSI RECIPIENT	A SSI recipient is a person who: • Has been approved to receive benefits • Receives benefits • Is approved for/or receiving benefits but the benefits are suspended, being recouped because of an overpayment or not paid because the amount is less than the maximum issuance amount.	E	N/A
RETAINED CASH AND INKIND PAYMENTS	If used by the AU for vacation purposes during the year annually produces income consistent with FMV or Produces income consistent with FMV Refer to Section 2420, for treatment of income from rental property for ABD Medicaid.	E	FBR - E NON-FBR - E
Non-liquid	Does not annually produce income consistent with FMV. Consider EV.	I	FBR - I NON-FBR - I
RETIREMENT FUNDS	*Refer to Pension Plan on page 2399-11 of this chart and Section 2332, Retirement Funds, and Section 2334, Savings and Checking Accounts.	*	FBR – * NON-FBR – *
RETIREMENT ACCOUNTS (including IRAs/Keoghs)	*Refer to Pension Plan on page 2399-11 of this chart and Section 2332, Retirement Funds.	*	FBR – * NON-FBR - *
REVERSE MORTGAGE	Allows a homeowner to borrow, via a mortgage contract, some percentage of the appraised value of their home. A periodic payment or line of credit is received and does not have to be repaid as long as the borrower resides in the home. Often referred to as a Reverse Annuity Mortgage (RAM).	E	FBR - Treat as a loan and count if retained in the month following the month of receipt. Refer to Section 2405. NON-FBR - SAME

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
SAFE DEPOSIT BOX Liquid	Secure storage in a bank or other institution where money and other valuables may be deposited Obtain a list of items that are in the box from the A/R. Count cash value of the items unless otherwise excluded. Refer to Section 2333.	I	FBR - Inventory required NON-FBR Inventory required only if statement of contents is questionable.
SALE-LEASEBACK	When a homeowner transfers title of the home to a buyer (e.g. an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn, allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. Under this arrangement, the buyer is responsible for the payment of real estate taxes, major maintenance, and casualty insurance.	N/A	FBR - Treat as the conversion of a resource and count if retained into the month following the month of receipt. If the buyer pays taxes, insurance or for repairs on the home the value of these items is ***not*** ISM to the former homeowner. Refer to Section 2405. NON-FBR - SAME
SAVINGS ACCOUNTS Liquid	Monies held in an interest bearing account Count CV. Refer to Section 2334.	I	FBR - I NON-FBR - I
SECURITY DEPOSIT ON RENTAL PROPERTY OR UTILITIES Liquid	Cash held by the provider and not accessible to the AU Cash returned to the AU. Resource in month received	E I	FBR - E NON-FBR - E FBR – I NON-FBR - I
SPENDING ACCOUNT Liquid	Funds which are held in an account to pay certain expenses such as child care or medical expenses	E	E
STOCKS AND MUTUAL FUNDS Liquid	A certificate which verifies ownership of shares in a company Consider CV. Count the value of stock at the time of the interview by verifying with the newspaper or a broker. Refer to Section 2335.	I	FBR - I (Refer to retirement funds in this chart for special instructions) NON-FBR - I

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
SUSAN WALKER V. BAYER CORPORATION SETTLEMENT PAYMENTS	Cash settlement from a law suit.	E	FBR – E NON FBR – SAME
TRUSTS Liquid	Any funds in a trust or transferred to a trust and the income produced by that trust If the: • Trust arrangement can be revoked by an AU member • Beneficiary's name can be changed during the POE • Trust arrangement can cease during the POE • Trustee administering the fund is a court, an institution, corporation or organization which is not under the direction or ownership of any AU member • Trustee appointed by the court has court imposed limitations placed on the funds • Trust investments made on behalf of the trust do not directly involve or assist any business or corporation under the control, direction or influence of an AU member.	 I N/A N/A E E E	Refer to Sections 2335, 2337, 2338, and 2339.
TRUST PROPERTY MEDICAID QUALIFYING Prior to OBRA '93	For description, refer to Section 2336.	N/A	FBR - Count as a resource any portion available to but not received by the A/R. Develop a transfer of resources for any portion unavailable to the A/R. Undue hardship may be considered. NON-FBR – SAME

Chart 2399.1 – Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
TRUST PROPERTY NON -MEDICAID QUALIFYING	For description, refer to Section 2337,	N/A	FBR - Exclude unless the A/R is legally empowered to revoke and use the funds. NON-FBR – SAME
UNIFORM GIFTS TO MINORS	For description, refer to Section 2340.	N/A	FBR - Exclude until age 21. If the A/R is a donor, develop for a transfer of resources. NON-FBR - SAME
UNIFORM LOCATION ASSISTANCE AND REAL PROPERTY ACQUISITION Liquid	Reimbursements received under PL 91-646, Section 210	E	E
VEHICLES Non-liquid	For description, refer to Section 2308.	Refer to Section 2308, Vehicles.	Refer to Section 2308, Vehicles, for how to count in FBR and Non-FBR COAs.
VICTIMS COMPENSATION (unspent)	For description, refer to Section 2341.	E	FBR - Exclude up to 9 months. Refer to chart 2. NON-FBR - SAME
WIC (Women Infants & Children Special Supplemental Food Program) Non-liquid	Vouchers which are redeemable for food items received by certain women and children considered to be nutritionally high risk.	E	E

Use the following chart to determine the resource treatment of income retained after the month of receipt

Chart 2399.2 – Resource Treatment of Income Retained After the Month of Receipt

Type of Income	Treatment for Month of Receipt	Month Any Portion Retained Becomes a Resource	Treatment of Any Interest Earned
Agent Orange	Exclude as income.	Never	Count as income and resource.
Austrian Social Insurance	Exclude as income.	Never	Count as income and resource.
Cash or In-Kind Payment to Replace or Repair Excluded Resources	Exclude as income.	10th month after month of receipt (exclude 9 calendar months). Exclude an additional 9 months if reason for retention is beyond A/R's control.	Exclude as income and resource during exclusion period.
Death Benefits	Count payments in excess of last illness and funeral expenses as income for the month of receipt.	2nd month after month of receipt if last illness and burial expenses are unpaid at receipt. 1st month after month of receipt if last illness and burial expenses paid before receipt.	Count as income and resource.
Disaster Assistance	Exclude as income.	Never	Exclude as income and resource.
Earned Income Tax Credit (EITC)	Exclude as income.	2nd month after month of receipt (exclude 1 calendar month)	Count as income and resource.
German Reparation	Exclude as income.	Never	Count as income and resource

Chart 2399.2 (Cont.) – Resource Treatment of Income Retained After the Month of Receipt

Type of Income	Treatment for Month of Receipt	Month Any Portion Retained Becomes a Resource	Treatment of Any Interest Earned
Home Replacement	Exclude as income.	ABD: 4th month after sale of home if A/R signs a statement of intent to buy a new home within 3 months. Family Medicaid: 7th month after sale of home.	Count as income and resource.
Japanese or Aleutian Restitution	Exclude as income.	Never	Count as income and resource.
Relocation Assistance	Exclude as income.	10th month after month of receipt or until May 1994 (exclude 9 calendar months)	Count as income and resource.
SSI and RSDI Lump Sums	Unearned Income.	7th month after month of receipt (exclude 6 calendar months)	Count as income and resource
Victims Compensation	Exclude as income.	10th month after month of receipt or until May 1994 (exclude 9 calendar months)	Count as income and resource.

NOTE: Except for SSI and RSDI lump sums, the above unspent resources must have met the exclusion from income requirements in order to be excluded from resources.

NOTE: Refer to Section 2305, Commingled Funds.

Use the following chart to determine if a benefit can be excluded from income and resources under Federal statutes other than Title XVI:

Chart 2399-3 – BENEFITS EXCLUDED FROM BOTH INCOME AND RESOURCES BY A FEDERAL STATUTE OTHER THAN TITLE XVI

Unspent funds or assets from the following sources are excluded resources:

- Action programs and domestic volunteer services
  - Volunteers in Service to America (VISTA)
  - University Year for Action (UYA)
  - special and demonstration programs
  - retired senior volunteer programs
  - foster grandparent programs
  - senior companion program
- Low income energy assistance – Any assistance in any form, if provided under the federal Low-Income Home Energy Assistance Program (LIHEAP), such as cash, vouchers, in-kind.
- Federal housing assistance – Any assistance in which the Department of Housing and Urban Development (HUD) or the Farmers Home Administration (FHA) is involved, such as cash for utilities, rental subsidies, etc.
- Food programs with federal involvement
  - USDA Food Stamps and USDA commodities
  - School lunches and breakfasts
  - WIC
  - Nutrition and other programs for older Americans under Chapter 35 of Title 42 of the US code
  - Meals furnished at senior citizens centers
  - Meals on wheels
  - Anything other than wages and salaries
- Educational assistance.

MEDICAID MANUAL TABLE OF CONTENTS		
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2401 – MEDICAID INCOME OVERVIEW

POLICY STATEMENT	All money, earned or unearned, received from any source by the Assistance Unit (AU) or the Medicaid Budget Group (BG) is considered in determining financial eligibility and benefit level. **EXCEPTION:** Medically Needy uses an income level to determine the A/R's excess income, or spenddown.
BASIC CONSIDERATIONS	Income is anything an A/R receives in cash or in-kind that can be used to meet basic needs for food, clothing or shelter. Income is considered on a monthly basis. Income is considered the month it is received by the A/R or becomes available without encumbrances to the A/R. An asset can never be considered as both income and a resource in the same month. Any income retained after the month of receipt becomes a resource on the first day of the month following the month of receipt. All lump sum payments are income in the month of receipt. **NOTE:** Any portion of a lump sum payment retained after the month of receipt is a resource. Refer to Section 2399, Chart 2399.1 - Resource Treatment of Income Retained after the Month of Receipt, for instructions on how to treat any portion of an RSDI or SSI lump sum payment retained after the month of receipt. Income is considered to be one of the following: • earned • unearned Specific deductions apply to income based on whether it is earned or unearned. For ABD Medicaid refer to Section 2505, Income Deductions. For Family Medicaid, refer to Section 2655, Family Medicaid Deductions.

PROCEDURES

Follow the steps below to determine whether to consider a particular source of income in determining financial eligibility:

Step 1 Determine who owns the income. Refer to Section 2403, Ownership of Income.

Step 2 Determine if the income is included or excluded in the Medicaid eligibility budget and in the ABD Medicaid patient liability/cost share budget if appropriate. Refer to Section 2405, Treatment of Income.

NOTE: If the income being considered is earned income, in-kind support and maintenance (ISM), rental income or self-employment income, refer to the special sections on these types of income in this chapter.

2403 – OWNERSHIP OF INCOME

POLICY STATEMENT	Income received by the Assistance Unit (AU) or Budget Group (BG) is considered in determining Medicaid eligibility.
BASIC CONSIDERATIONS	Income can be owned solely or jointly. An agent or organization acting on behalf of an A/R can also receive the income. The source of income must be identified to determine if the income is included or excluded. Refer to Section 2499, Treatment of Income in Medicaid. All countable income of the AU or BG is applied to the income limits for the class of assistance being applied for. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, and Chapter 2650, Family Medicaid Budgeting for budgeting procedures.
PROCEDURES	Include all income owned solely by the A/R in determining eligibility if it is accessible to the AU or BG for daily use because the AU or BG has the legal ability to use it.
Jointly Received Income in Family Medicaid	If an AU or BG member receives income jointly with another person or a group of persons, the portion that belongs to the AU or BG member is determined as follows: • If there is an agreement between the parties that specifies how they will divide the income, this agreement is used to determine the amount of income to consider. • If there is no agreement, a pro rata share of the income is counted to the member whose income is being considered.
Jointly Owned Income in ABD Medicaid	When a financial instrument, such as a bank account, is owned jointly by the A/R and another individual, determine what portion of any deposit or interest represents income to the A/R. **NOTE:** The A/R may rebut ownership of income. For the rebuttal process, refer to Chapter 2300, Resources.

PROCEDURES
(cont.)

For ABD Medicaid, use the following chart to determine the amount of income generated by a joint financial account to consider as income to the A/R:

Chart 2403.1 - Determining Income from a Joint Financial Account	
IF the account is	**THEN**
jointly owned by the A/R and an ineligible individual(s)	consider the amount of any interest posted as income to the A/R AND include the full amount of any deposit made by the A/R, the ineligible bank account holder or a third party as income to the A/R. **EXCEPTION:** Income that clearly is owned by another account holder, e.g. direct deposit RSDI, is income to the owner of said income.
jointly owned by two or more A/Rs	allocate any interest posted equally among the joint owners AND do not consider deposits made by joint holder as income to the other joint holder.

For ABD Medicaid, use the following chart to determine the treatment of income from a jointly held account after the A/R successfully rebuts ownership of the account:

Chart 2403.2- Determining Income from a Joint Account after the A/R Rebuts Ownership	
IF	**THEN**
the A/R successfully rebuts ownership of a portion of funds in a joint account	do not consider deposits made by the other account holder as income to the A/R. Charge interest to the A/R in proportions to the percentage of funds that are a resource to the A/R.
the A/R successfully rebuts ownership of all funds in a joint account	do not consider deposits made by the other account holder(s) OR interest posted to the account as income to the A/R.

SPECIAL CONSIDERATIONS FOR ABD MEDICAID	
A/R Has an Agent	Treat income received by an agent acting on behalf of an A/R as if the A/R received the income directly.
A/R Is the Agent	Do not consider income received by an A/R in his/her capacity as an agent as income to the A/R. Consider fees, commissions or contributions for services rendered as unearned income to an A/R acting as an agent.

2405 – TREATMENT OF INCOME

POLICY STATEMENT

Money received is considered to be either earned or unearned. Different rules apply to each type. Either type may be cash or in-kind.

BASIC CONSIDERATIONS

Earned income consists of the following types of payments:

- wages
- net earnings from self-employment (NESE)
- payments for services performed in a sheltered workshop or work activities center
- payments or refunds of earned income tax credits
- royalties and honoraria
- sick pay received within six months after work stopped.

Wages include but are not limited to the following:

- salaries
- bonuses
- severance pay
- other special payments received because of employment
- the value of food, clothing or shelter in lieu of wages (in-kind earned income. Counted in ABD Medicaid only.)

Unearned income is all income that is not earned. The following are types of unearned income:

- alimony
- annuities, pensions, and other periodic payments
- benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient
- dividends, interest and royalties
- in-kind support and maintenance (ISM)
- prizes and awards
- rent.

BASIC CONSIDERATIONS (cont.)

Income Not Included in Determining Financial Eligibility

The following are not considered income, and are disregarded when determining Medicaid eligibility:

- bills paid by a third party (vendor payment) for an item other than food, shelter or clothing
- conversion of a resource, such as selling a car to get cash.

  NOTE: The cash received from conversion of a resource is not counted as income in the month of conversion. Any cash remaining on the first day of the month following the month of the conversion is a resource.

- credit life or credit disability insurance payments
- earned income tax credits (EITC)
- income tax refunds
- non-cash items which will be excluded or partially excluded as a resource after the month of receipt, such as a vehicle excluded because it is used for medical treatment.

  EXCEPTION: Food, shelter or clothing are always assigned a value as ISM and included in the eligibility budget as unearned income for ABD Medicaid A/Rs in LA-A, B or C.

- medical or social services provided as cash or in-kind
- proceeds of a loan
- rebates and refunds
- replacement of income which is lost, stolen or destroyed after receipt (e.g., replacement government checks)
- return of erroneous payments
- value of personal services (e.g., mowing the lawn)
- Veteran's Aid and Attendance
- Veteran's Household Allowance
- Veteran's Unusual Medical Expense (UME) reimbursement
- weatherization assistance (storm doors, windows, insulation, etc.)

BASIC CONSIDERATIONS (cont.)

Sick Pay

Consider a payment made to or on behalf of an employee by an employer or a private third party because of sickness or accident disability to be Sick Pay.

Consider any Sick Pay received through the six full months after the month work stopped because of sickness or accident to be earned income. Thereafter, consider as unearned income.

In-Kind Items

For ABD Medicaid, develop the value of food, clothing, shelter or other items provided in lieu of wages for the possibility of earned income.

Include the value of the food and/or shelter as ISM (unearned income) using the presumed maximum value (PMV) rule if both the following conditions are met:

- the food and/or shelter is furnished for the employer's convenience and on his/her premises
- the shelter is provided as a condition of employment

If either of the above conditions is not met, include the current market value (CMV) of the food and/or shelter as wages.
Consider as earned income payments that an individual receives for services performed in a sheltered workshop or work activities center while participating in a program designed to help him/her become self-supporting.

Payments for Services Performed in a Sheltered Workshop or Work Activities Center

Consider a work environment to be a sheltered workshop if it is a nonprofit organization or institution whose purpose is the following:

- to carry out a recognized program of rehabilitation for handicapped workers
- to provide such individuals with remunerative employment or other occupational activity of an educational or therapeutic nature.

Consider a work environment to be a work activity center if it is planned and designed exclusively to provide therapeutic activities for handicapped workers whose physical or mental impairment is severe as to make their productive capacity inconsequential.

Income from a Terminated Source at Application

If an A/R reports a terminated source of income, the facts regarding the termination, the date on which the final payment of income was received must be verified **only** if questionable.

PROCEDURES

Determine whether the specific type(s) of income received by the A/R is included or excluded in the eligibility and patient liability/cost share budgets by referring to Chart 2499.1 - Treatment of Income in Medicaid.

Include income in the budget at the earliest of the following points:

- when they are received
- when they are credited to the individual's account
- when they are set aside for the individual's use.

If the income is to be included in the budget, determine how much of the income is included. Refer to Section 2504, Determining Countable Income.

Apply the appropriate income deductions, based on whether the income is earned or unearned, when the income is included in the eligibility and patient liability/cost share budgets. For ABD Medicaid, refer to Section 2505, Income Deductions, and Section 2552, Patient Liability Deductions. For Family Medicaid refer to Section 2655, Family Medicaid Deductions.

Income Considerations

Eligibility based on income is determined by resolving the following series of questions:

- What is the income limit for type of assistance requested?
- Whose income is considered?
- What is the source of the income?
- Is the income available to the AU to meet its needs?
- Is the income included or excluded?
- How often is the income received?

Income of the following individuals may be considered when determining eligibility:

- AU or BG members
- Persons whose income must be deemed to the AU
- Deemed income of sponsors of aliens
- Ineligible aliens
- Ineligible parents
- Penalized individuals

Refer to Chapter 2500, ABD Financial Responsibility and Budgeting and Chapter 2650, Family Medicaid Budgeting.

PROCEDURES (cont.)

Documentation

For each type of income received, the following must be documented:

- Source of income
- Individual(s) receiving income
- Frequency (monthly, weekly, bi-weekly, etc.) of payment
- Day of week income is received
- Gross amount
- Source of verification.

NOTE: If the date of receipt of income or the amount of income cannot be reasonably anticipated, the income is not counted. The decision must be documented.

In addition, the following information must be documented if the income is earned:

- Beginning/ending date of employment (if applicable)
- Employer's name, address and telephone number
- Date on which new or increased earnings are received.

Verification

In all Family Medicaid COAs the A/R's statement of the source and amount of income, earned or unearned may be accepted unless questionable. For ABD Medicaid, the A/R's statement is only acceptable for QMB, SLMB, QI-1 and QI-2 COAs. Verification is required when information available to the agency contradicts the A/R's statement or the statement is otherwise questionable.

Verification of income, if required by policy, is obtained in the following order:

- The A/R should provide verification from the payment source.
- If the A/R cannot obtain the verification, the agency must request it directly from the payment source.
- Verification can be obtained from a collateral source, a person who has knowledge of the income, if verification cannot be provided by the payment source.
- The statement of the A/R may be accepted if all other attempts to verify income are unsuccessful and the A/R has cooperated with previous attempts to obtain verification.

PROCEDURES (cont.)

Means of Verification - all Medicaid COAs

Verification of income can be provided in a variety of ways, including:

- Pay stubs
- Award letter
- Copy of check
- Written statement
- Computer match

2410 – RENTAL INCOME

POLICY STATEMENT

Any rental payment which an A/R receives for the use of real or personal property, such as land, housing or machinery is included as income to the A/R in the Medicaid financial eligibility and patient liability/cost share budget.

BASIC CONSIDERATIONS

Net rental income is gross rent less the ordinary and necessary expenses paid in the same federal/state income tax year.

Ordinary and necessary expenses are those necessary for the production or collection of rental income. These expenses include the following:

- interest on debts
- state and local taxes on real and personal property and on motor fuel
- general sales taxes
- expenses of managing or maintaining property.

Net rental income is unearned income unless it is earned income from the self-employment of someone who is in the business of renting properties.

PROCEDURES

Deductible Expenses

Deduct the following ordinary and necessary expenses as expenses for the month they are paid:

- the interest and escrow portions of a mortgage payment at the point the payment is made to the mortgage holder
- repairs such as minor corrections to an existing structure
- property taxes
- fire and hazard insurance
- lawn care
- snow removal
- advertising for tenants.

Nondeductible Expenses

Do **not** deduct the following expenses from rental income:

- the principal portion of a mortgage payment
- a capital expenditure, which is an expense for an addition to or increase in the value of the property
- the property depreciation amount claimed as a federal income tax deduction.

PROCEDURES (cont.)

Determining Net Rental Income

Follow the steps below to determine net rental income to include in the eligibility and patient liability/cost share budgets.

Step 1

Determine the gross rent received and the deductible expenses paid each month.

Step 2

Subtract the deductible expenses from the gross rent to determine the net rental income.

Step 3

If the expenses exceed the gross rent for a month, deduct the excess expenses as follows:

- Subtract the excess expenses from the next month's gross rent.
- Continue to subtract the excess expenses from each month's gross rent through the end of the tax year.

Step 4

If excess expenses remain after subtracting expenses through the end of the tax year, deduct the remaining excess expenses as follows:

- Subtract the excess expenses from the gross rent received in the month prior to the month the expenses were paid.
- Continue subtracting the excess expenses from each month's gross rent as necessary back to the beginning of the tax year until they are exhausted.

VERIFICATION

Use documents in the individual's possession such as bills, receipts, etc., to verify the gross rent and the dates received, and the expenses and the dates paid.

NOTE: The individual's most recent federal tax return including Schedule E is helpful in identifying past expenses and in estimating future rental income.

If documents are not available, obtain a signed statement from the A/R. Include an allegation of the gross rent and expenses paid for the period involved.

NOTE: Do not contact the tenants to verify the allegations.

Contact the local Internal Revenue Service (IRS) or refer to IRS Publication 527 if you are uncertain whether an expense is allowable, such as whether it is an incidental repair or a capital expenditure. Document the information obtained from the IRS.

SPECIAL CONSIDERATIONS

Apportion net rental income equally when there is more than one owner.

- Split the gross rent between two joint owners before expenses are paid.
- Deduct expenses paid by the A/R from his/her portion of the gross rent.
- Accept a signed statement from the A/R if it explains why apportionment should not be equal.

Use evidence from the retroactive period to estimate net rental income for the next 12 months. Deduct only predictable expenses, such as utilities, interest payments, taxes, etc.

Deduct an unpredictable expense if reported in the month paid. If the expense exceeds the rent for that month, recalculate the rest of the estimated period as necessary using the steps in *Determining Net Rental Income* under PROCEDURES in this section.

Use an individual's amortization schedule to determine the mortgage interest expense. If a schedule is not available, divide the yearly interest by twelve to determine monthly interest.

2415 - SELF-EMPLOYMENT

POLICY STATEMENT	Net earnings from one's own business or profession, rather than as a specified salary or wages from an employer, is included as earned income when determining eligibility for any Medicaid Class of Assistance (COA) and when determining ABD patient liability/cost share budgets.
BASIC CONSIDERATIONS	The net earnings from self-employment (NESE) is the gross income from any trade or business plus capital gains, if any, less allowable business expenses, including depreciation. NESE also includes any distributive share (whether or not distributed) of income or loss from a trade or business carried on by a partnership. Appreciation, or capital gain, is an increase in the value of a business resource because of any of the following: • improvement in the property • normal market increases • interest accrued Determine appreciation by obtaining verification of the value of the resources from a reliable source. Depreciation occurs when a business resource loses value because of either of the following: • destruction of property in a storm, fire or other disaster • long term use of the resource reduces its value (e.g., vehicles, machinery) Determine depreciation by obtaining verification of the value of the resource from a reliable source.
PROCEDURES FOR ABD MEDICAID	Develop NESE in the following situations: • The A/R was self-employed in the prior tax year. • The A/R is currently self-employed. • The A/R has been self-employed during the current tax year.

PROCEDURES FOR ABD MEDICAID (cont.)

Calculate NESE on a tax year basis.

- Subtract all allowable IRS business deductions claimed on the self-employed individual's federal tax return from the gross self-employment earnings for the year to get the NESE.

- Divide the NESE equally among the 12 months in the tax year to get the earnings for each month.

Divide net losses from self-employment over the tax year in the same way as net earnings. Deduct each month's net loss from other earned income for that month.

Divide the entire taxable year's NESE equally among 12 months in the taxable year, even if the business is seasonal, starts late in the year, ceases operation before the end of the tax year or ceases operation prior to the initial application for ABD Medicaid.

When a member of a Medicaid couple, a Medicaid individual, a Medicaid individual's ineligible spouse or one of two ineligible parents incurs a verified net loss, deduct it from other earnings for the tax year in which the loss was incurred, regardless of which individual incurred the loss.

When an individual alleges (or you discover) that cash or in-kind items are withdrawn from a business for personal use, ascertain whether the withdrawals were properly accounted for in determining NESE. Accept the individual's allegation that withdrawals were deducted on his/her tax return in determining the cost of goods sold or that they were deducted on his business records. If they were deducted, then they were properly accounted for.

PROCEDURES FOR FAMILY MEDICAID

Rental Property

Consider self-employment income from rental property as follows for:

IF AU MEMBER(S) IS	THEN COUNT
actively involved in property management at least 20 hours per week.	the gross income less cost of doing business as earned income.
not actively involved in property management at least 20 hours per week.	the gross income less cost of doing business as unearned income.

PROCEDURES FOR FAMILY MEDICAID (cont.)

Capital Gains

Consider the total proceeds from the sale of capitol goods or equipment, less depreciation, as capital gains income.

Add capital gains income to the gross self-employment income.

Business Expenses

Deduct from the gross self-employment the expenses listed in Chart 2425.1 related to the operation of a self-employment enterprise. Refer to Chart 2425.1, Cost of Doing Business.

Boarder Income

The recipient of boarder income is entitled to the actual, documented cost of doing business.

CHART 2425.1 - COST OF DOING BUSINESS FOR FAMILY MEDICAID

ALLOWABLE EXPENSES	UNALLOWABLE EXPENSES (All Inclusive)
labor costs	payment on the principal of the purchase price of income-producing real estate, equipment, machinery, etc.
stocks, raw materials, seeds, fertilizer	local state and federal income taxes
interests on payments on loans for equipment, real estate, or other loans used in producing income	income set aside for retirement
insurance premiums on real estate or equipment	personal expenses (transportation to and from work, living expenses)
property taxes on income-producing property	depreciation on equipment, real estate, etc.
job-related transportation costs.	

PROCEDURES FOR FAMILY MEDICAID (cont.)

Treatment of Income

Annualize self-employment income if the following occurs:

- the self-employment income represents a year's support, even if the income is received in a short time period
- the self-employment income accurately reflects the AU's current circumstances.

NOTE: Annualize the self-employment income even if the AU receives additional income from other sources.

Do not annualize self-employment income if the following occurs:

- the self-employment income is not an accurate picture of the AU's current circumstances because income has recently increased or decreased
- the self-employment income represents support for only a part of the year
- the self-employment income is from a new business in operation less than one year.

Use the procedures in Chart 2425.2 to annualize self-employment income:

CHART 2425.2 - HOW TO ANNUALIZE SELF-EMPLOYMENT INCOME FOR FAMILY MEDICAID

IF THE INCOME IS RECEIVED	THEN
annually (even if received in a short period of time)	total gross receipts, less cost of doing business, and divide by 12 to determine monthly amount to budget.
periodically but represents one year's support	total gross receipts of the annual income, less cost of doing business, and divide by 12 to determine the monthly amount to budget.
monthly	total gross receipts less cost of doing business, and divide by 12 to determine monthly amount to budget.

Use Chart 2425.3 to determine treatment of income which is not annualized:

CHART 2425.3 - HOW TO COMPUTE INCOME WHICH IS NOT ANNUALIZED FOR FAMILY MEDICAID	
IF THE INCOME	**THEN**
does not reflect current circumstances (recent increase or decrease in income)	determine the best estimate of current gross income less cost of doing business to be used as the monthly amount budgeted.
is from a new business, i.e., in operation less than one year	average gross income less cost of doing business over the period of operation to determine projected monthly income.
represents support for only part of the year	average gross income less cost of doing business over the number of months the income is intended to cover.
is received monthly	count total gross monthly income less cost of doing business.

PROCEDURES FOR FAMILY MEDICAID (cont.)

Budgeting Procedures Follow the steps below to determine income for inclusion in the budget.

Step 1 Add all gross self-employment income.

Step 2 Add any capital gains, less depreciation.

Step 3 Subtract the cost of doing business.

Step 4 Consider the result as the adjusted gross self-employment income.

Step 5 Calculate deductions and benefit level as for any other AU.

Refer to Chapter 2650, Family Medicaid Budgeting.

VERIFICATION

ABD Medicaid and Family Medicaid

Verify gross self-employment earnings and allowable IRS deductions through the use of any of the following:

- federal income tax return
- business records including receipts, bills and invoices
- the A/R's signed statement if neither of the above are available.

NOTE: Assume that any deductions taken on a tax return or business record is allowable by the Internal Revenue Service.

Document the case record as to why federal income tax returns or business records were not used if the A/R's statement was accepted as verification.

2420 - MILITARY PAY

POLICY STATEMENT	Military pay, housing allowance, subsistence allowance and other entitlements as shown on the Leave and Earnings Statement (LES) are considered when determining eligibility or assistance.
BASIC CONSIDERATIONS	Military pay is treated as earned income when the person in the military is an AU member. When a person in the military is not in the AU but gives money to the AU or authorizes money to be sent to the AU, that money is counted as unearned income. The Clothing Maintenance Allowance (CMA) is treated as a reimbursement. Military pay is counted in the month for which it is intended. **EXCEPTION:** Advance Pay, Casual Pay and Family Subsistence Supplemental Allowances are counted in the month received.
PROCEDURES	Chart 2451.1 provides information on the treatment of military pay. Determine if there are any debt repayments listed on the LES and treat as follows: • if a debt repayment is for Advance Pay, then deduct the repayment from the gross income • if a debt repayment listed as FININ or Debt Repayment on LES is for a personal loan (e.g., for a car loan), count the repayment as part of the gross income. Do not allow the following deductions or exclusions from income: • allotments withheld for dependents **EXCEPTION:** Allow as an exclusion if it is for an ineligible child or for a voluntarily excluded child in Family Medicaid. • federal tax, FICA, SGLI, Soldiers Home, Insurance.

Use the chart below to determine treatment of military pay.

CHART 2451.1 - TREATMENT OF MILITARY PAY

BENEFIT	TREATMENT OF INCOME
Amount Brought Forward	Disregard amounts brought forward from a previous month.
Advance Pay/Casual Pay	Count the gross amount as earned income in the month received.
Base Pay	Count the gross amount as earned income in the month received.
Basic Allowance for Housing (BAH)	Count the gross amount as earned income in the month for which is it intended. The BAH is one monthly payment, replacing the Variable Housing Allowance (VAA) and Basic Allowance for Quarters (BAQ).
Basic Allowance for Subsistence (BAS)	Count the gross amount as earned income in the month for which it is intended.
Career Sea Pay	Count the gross amount as earned income in the month for which it is intended.
Clothing Maintenance Allowance (CMA)	Do not count as income. Consider it as a reimbursement. Deduct the CMA from the total gross earned income.
Cost-of-Living Allowance (COLA) or HOUSE	Count the gross amount as earned income in the month for which it is intended.
Fly Pay/Fly Pay-non	Count the gross amount as earned income in the month for which it is intended.
FSSA	Count the gross amount as earned in the month received. Family Subsistence Supplemental Allowances are given to assist low-income military families.
Jump Pay	Count the gross amount as earned income in the month for which it is intended.
Leave or Separate Rations	Count the gross amount as earned income in the month for which it is intended.
National Guard Pay	Count the gross amount as earned income in the month for which it is intended.
Pro-Di	Count the gross amount as earned income in the month for which it is intended.
Reenlistment Bonus	Treat the gross amount as a non-recurring lump sum payment. **EXCEPTION:** If paid in installments, count as unearned income in the month received.
Regular Sea Pay	Count the gross amount as earned income in the month for which it is intended.

2430 - LIVING ARRANGEMENT AND IN-KIND SUPPORT AND MAINTENANCE FOR ABD MEDICAID

POLICY STATEMENT

In-kind support and maintenance (ISM) is considered as unearned income when establishing financial eligibility for ABD Medicaid. This policy does not apply to Family Medicaid.

BASIC CONSIDERATIONS

ISM is unearned income in the form of food, clothing or shelter provided to the Medicaid individual/couple or Medicaid child.

The value of ISM received by the Medicaid individual/couple is determined by subtracting the individual/couple's financial contribution toward household operating expenses from the value of food, clothing or shelter provided to the individual/couple by another individual.

The following two rules are used to value the ISM an individual/couple receives:

- the presumed maximum value (PMV) rule
- the value of the one-third reduction (VTR) rule.

Presumed Maximum Value (PMV) Rule

The PMV is one-third of the full FBR plus $20.00.

The PMV rule is used to value ISM received by a Medicaid individual/ couple residing in Living Arrangement A or C (LA-A or C).

Under PMV, the value of ISM is determined as follows:

- The actual value (AV) of all food and shelter received by the household is determined.
- The ISM is included in the eligibility budget as unearned income using the AV or PMV, whichever is less.

Value of the One-Third Reduction (VTR) Rule

The VTR is the full SSI Federal Benefit Rate (FBR) reduced by one-third.

The VTR rule is used to value ISM received by a Medicaid individual/ couple residing in Living Arrangement B (LA-B).

The VTR is used if the Medicaid individual/couple meets both the following criteria:

- The individual lives throughout a month in another person's household.
- The individual receives both food and shelter from others living in that household.

BASIC CONSIDERATIONS

Value of the One-Third Reduction (VTR) Rule (cont.)

Refer to Living Arrangement B (LA-B under PROCEDURES in this section) for more information on applying the VTR rule.

NOTE: The two rules for valuing ISM are mutually exclusive. When the VTR rule is applied to ISM received in a month, the PMV rule cannot be applied to the same month.

Living Arrangement Codes

The Medicaid individual/couple's living arrangement is determined in order to select the appropriate means for placing a value on ISM (PMV or VTR).

There are four Living Arrangements: A, B, C and D.

The living arrangement is developed in the following order:

- D
- B
- A or C

EXCEPTION: Always consider QMB, SLMB, QI-1 and QI-2 and non-LA-D AMN individuals/couples to be residing in LA-A. **DO NOT** develop ISM for QMB, SLMB, QI-1, QI-2 and LA-D individuals/couples. ISM must be developed for non-LA-D AMN A/Rs.

PROCEDURES

Follow the steps below to determine the amount of ISM to consider in the eligibility budget:

Step 1 Determine the Medicaid individual/couple's living arrangement (LA).

Step 2

Value ISM based on the LA determined in Step 1.

- If the individual resides in LA-D, do not develop ISM.
- If the individual resides in LA-A or LA-C, develop the AV of ISM. Include ISM not to exceed the PMV in the Medicaid eligibility budget.
- If the individual resides in LA-B, value ISM using the VTR.

PROCEDURES (cont.)

Living Arrangement D (LA-D)

Consider a Medicaid individual who resides in any of the following situations to be in LA-D:

- hospital confinement that meets LOS
- nursing home (NH) confinement
- receipt of CCSP, MRWP/CHSS or ICWP services at home
- receipt of hospice care at home
- receipt of Model Waiver services at home
- receipt of SSI or ABD Medicaid at home under a Deeming Waiver
- MRWP/CHSS.

NOTE: DO NOT develop ISM for individuals residing in LA-D.

Living Arrangement A (LA-A)

Consider the Medicaid individual/couple to be residing in LA-A if any one of the following situations exists:

- The individual lives alone or with no adults other than his/her spouse.
- The individual has an ownership interest in his/her home.
- The individual has rental liability for his/her home.
- The individual lives in a Public Assistance (PA) household.
- The individual is a transient.
- The individual can show separate consumption of food.
- The individual can show separate purchase of food.
- The individual is sharing household expenses.
- The individual is earmarking his/her share of household expenses, known as earmarked sharing

Home Ownership

Consider the Medicaid individual/couple to have home ownership interest if s/he or his/her spouse has ownership interest of any of the following types:

- life estate interest
- partial ownership, such as a ½ undivided interest
- title or deed (full ownership)
- trust beneficiary
- unprobated estate interest
- warranty deed (the property is mortgaged).

Verification

Accept the individual's statement unless questionable.

PROCEDURES (cont.)

Rental Liability

Consider the Medicaid individual/couple to have rental liability if the individual or his/her spouse has agreed to pay the landlord a specified amount periodically (monthly, weekly, etc.).

NOTE: Rental liability exists whether rent is actually being paid or if rent paid is less than the current market rental value as long as the agreement is still in effect.

Verification

Accept the individual's statement of rental liability if s/he lives alone or with his/her spouse and/or dependent child. Verify rental liability for all other living situations.

Public Assistance Household

Consider the Medicaid individual/couple to live in a public assistance household (PA household) if each household member receives **one** of the following types of income:

- Temporary Assistance for Needy Families (TANF)
- Bureau of Indian Affairs general assistance programs
- Payments based on need which are provided under state or local government income maintenance programs
- Payments under the Disaster Relief Act of 1974
- Payments under the Refugee Assistance Act of 1980
- Supplemental Security Income (SSI)
- Veteran's Administration (VA) benefits that are based on need.

  NOTE: Effective November 1, 1981, when a VA pension or compensation based on need includes an augmentation for a dependent, the dependent's portion of the VA payment is counted as income to him/ her. Such dependents are considered public assistance recipients.

Verification

Verify that all household members receive public assistance.

Transient

Consider a Medicaid individual to be a transient if s/he has no permanent living arrangement.

Verification

Accept the individual's statement as verification.

PROCEDURES (cont.)

Separate Consumption of Food

Consider separate consumption of food to exist when all the following conditions are met:

- The Medicaid individual/couple lives in a household with at least one other person other than a spouse, child, or person whose income is deemed to the individual.
- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or at least one member of a couple, alleges eating no meals in the household during the month.

Verification

Obtain the individual's signed statement regarding separate consumption and verify the allegation with a knowledgeable adult member of the household other than the individual's spouse.

Separate Purchase of Food

Consider a separate purchase of food exists when all of the following conditions are met:

- The Medicaid individual/couple lives in a household with at least one person other than a spouse, child, or person whose income is deemed to the individual.
- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or both members of a couple, eats meals in the household during a month.
- The individual, or at least one member of a couple, alleges buying his/her food apart from the food of other household members.

Verification

Obtain the individual's signed statement regarding separate purchase of food and verify the allegation with a knowledgeable adult member of the household other than the individual's spouse.

PROCEDURES (cont.)

Sharing

Consider the Medicaid individual/couple to be sharing when all the following conditions are met:

- The individual lives in a household with at least one person other than a spouse, child, or person whose income is deemed to the individual.
- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or both members of a couple, does not separately consume his/her food.
- The individual, or both members of a couple, does not separately purchase his/her food.
- The individual with ownership interest or rental liability makes a contribution toward the household operating expenses.

or

the individual without ownership interest or rental liability makes a contribution toward any expense of the person with ownership interest or rental liability, such as household operating expenses, credit card payments, telephone bill or furniture bill.

Allowable household operating expenses include the following:

- food
- mortgage (including property insurance required by the mortgage holder)
- rent
- real property taxes
- heating fuel
- gas
- electricity
- water
- sewage
- garbage removal.

NOTE: The use of land alone is not a shelter cost. This means that an item such as a trailer space rental fee that does not include water, sewage, etc., is not a household operating expense for purposes of determining sharing.

PROCEDURES

Sharing (cont.) Follow the steps below to perform a sharing computation:

Step 1 Determine the average household operating expenses.

Step 2 Determine the household composition.

Step 3 Determine the individual's pro rata share of household expenses by dividing the household operating expenses by the number of household members. Assume all other members of the household share in the food expense unless information is obtained to the contrary. If another member of the household does not share in the food, determine separate pro rata shares for food and shelter and add them together to determine the individual's pro rata share.

Step 4 Determine the individual's average monthly contribution toward household expenses.

Step 5 Compare the contribution to the pro rata share.

If the contribution is within $5 less than or greater than the pro rata share of expenses, consider the contribution and the pro rata share to be equal, and consider the individual to be sharing.

NOTE: When computing sharing for a Medicaid couple, subtract the couple's contribution from the pro rata share of household expenses multiplied by 2 to determine if sharing exists.

Verification Obtain signed statement(s) of household expenses and contributions to establish that an individual is sharing.

PROCEDURES (cont.)

Earmarked Sharing

Consider the Medicaid individual/couple to be earmarked sharing when all the following conditions are met:

- The individual lives in a household with at least one person other than his spouse, child, or a person whose income is deemed to the individual.
- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or both members of an eligible couple, does not separately consume his/her food.
- The individual, or both members of a couple, does not separately purchase his/her food.
- The individual does not contribute within $5 of his/her pro rata share of household operating expenses for food and shelter.
- The individual, or at least one member of a couple, alleges earmarking part or all of his/her contribution toward the household food or shelter expense.

Computation

Verify household expenses and compute earmarked sharing in the same manner as sharing, comparing the individual's contribution toward the earmarked expense to his/her pro rata share of the expense. However, do not allow a $5 tolerance for earmarked sharing.

Verification

Use the verification procedures for sharing.

Double Earmarking

When an individual earmarks a specific portion of his/her contribution for food and another specific portion for shelter, it is called double earmarking.

Compute the individual's pro rata share of food expenses and compare it to the portion of the contribution earmarked for food.

Compute the individual's pro rata share for shelter expenses and compare it to the portion of the contribution earmarked for shelter.

If either earmarked contribution equals or exceeds a pro rata share of the item for which it is earmarked, consider earmarked sharing to exist. The individual is receiving ISM in the form of the item for which s/he is not earmarking. Value this ISM under the PMV rule.

PROCEDURES

Double Earmarking Verification

If the individual makes a contribution, verify the contribution as follows:

- Obtain the individual's statement regarding earmarking.
- Obtain an additional signed statement from a knowledgeable adult member of the household other than the individual's spouse. This statement should confirm the amount of the earmarked contribution and the household operating expenses for food or shelter, or both if these expenses were not obtained for a sharing determination.

NOTE: If evidence of household operating expenses and the earmarked contributions cannot be obtained, consider the individual to be residing in LA-B.

Living Arrangement C (LA-C)

Consider a Medicaid individual to be residing in LA-C if all of the following conditions exist:

- The individual is a disabled child under age 18.
- The individual lives with his/her parent(s).
- The individual's parents have ownership interest or rental liability in the home.

NOTE: A disabled child residing at home under the Deeming Waiver or Model Waiver class of ABD Medicaid is considered to be residing in LA-D.

ISM for an Individual/ Couple in LA-A or C

If a Medicaid individual or couple in LA-A or LA-C receives an item(s) of food, shelter or clothing during the month from an individual(s) other than:

- spouse or dependent children for LA-A
- parents or minor siblings for LA-C,

place a value on this item(s) and include the value in the eligibility budget as ISM for the month of receipt.

PMV Rule

Use the PMV rule when an individual in LA-A or C receives ISM.

Rebuttal of the PMV Rule

Use of the PMV rule differs from use of the VTR in that an individual may rebut the value assigned to the PMV. If the individual produces evidence that establishes the AV of the ISM is lower than the PMV, use the AV as the value of the ISM.

PROCEDURES (cont.)

Eligible Expense for Computing ISM

To compute ISM for a Medicaid individual/couple in LA-A or C, use the household operating expenses listed under Sharing in this section.

NOTE: The use of land alone is not a shelter cost. This means that an item such as a trailer space rental fee which does not include water, sewage, etc., is not a household operating expense for purpose of determining inside ISM, nor is it an item of outside ISM if someone outside the household pays the fee. If the fee is not for use of land alone, that part of the fee for water, sewage, etc., is part of the household operating expenses.

Verification

Obtain a signed statement(s) of household expenses.

Types of ISM

Consider the following two types of ISM for a Medicaid individual/ couple in LA-A or LA-C:

- Inside ISM is ISM received from other members of the household in which the individual resides.
- Outside ISM is ISM received from someone outside of the household.

EXCEPTION: Do **not** develop Inside or Outside ISM for QMB, SLMB, QI-1 and QI-2 individuals/couples.

Inside ISM

Develop Inside ISM for a Medicaid individual/couple in LA-A only if the basis for residing in LA-A is one of the following:

- ownership
- rental ability
- separate consumption of food
- separate purchase of food
- earmarked sharing.

PROCEDURES

Inside ISM (cont.)	Develop Inside ISM for a Medicaid individual in LA-C only when there are persons residing in the home other than the individual and his/her parents and other minor children. Compute Inside ISM in the following manner: • Determine the total household operating expenses. • Divide the total household operating expenses by the number of household members to determine the individual's pro rata share of household expenses. • Deduct the individual's or couple's contribution from the individual's or couple's (individual share multiplied by 2) pro rata share to determine AV of the Inside ISM.
Outside ISM	Develop Outside ISM for all Medicaid individuals/couples residing in LA-A or LA-C. Compute Outside ISM in the following manner: • Use the current market value (CMV) of the item or shelter or food paid by someone outside of the household. • Deduct from the CMV any payment made by household members toward that item. • Divide the balance by the number of household members to obtain the AV of the ISM to the individual.
Total Inside and Outside ISM	Total the AVs of the Inside and Outside ISM. Use the total AV or the PMV, whichever is less, as the value of ISM to the Medicaid individual/ couple.
Living Arrangement (LA-B)	Consider the Medicaid individual/couple to be residing in LA-B if both of the following conditions exist: • The individual lives in the household of another. • The individual is not residing in LA-A or C (because they are not paying their fair share of household expenses) or D.
VTR **FBR for LA-B**	If the individual is determined to be in LA-B, value ISM using the VTR. The VTR is equal to one third of the individual or couple FBR for LA-A.
Rebuttal of the VTR	Use the FBR for LA-B in order to account for the VTR. Use of the FBR for valuing ISM **cannot** be rebutted by the A/R.

SPECIAL CONSIDERATIONS

ISM to a Child in LA-C

When computing ISM for a child in LA-C, apply the parent(s)' contributions to their own pro rata share(s) of household operating expenses first. Apply any amount of their contributions **exceeding** their pro rata share(s) of household operating expenses to their child's pro rata share of household operating expenses.

If the child lives with only his/her parent(s) and other minor children, develop Outside ISM only.

If the child lives with other adults in addition to his/her parent(s), develop Inside and Outside ISM.

NOTE: Do **not** deem ISM received by the parent(s) to the child in the Parent to Child Deeming budget.

ISM is a Result of a Third Party Vendor Payment

When a third party payment from outside the household is made directly to a vendor for an item of food, clothing or shelter, it results in ISM to the Medicaid individual/couple.

Include ISM received as the result of a third party vendor payment as income for the month the food, clothing, or shelter is available to the individual to use.

If a vendor extends credit to the individual and the third party pays for (or makes a payment on) food, clothing, or shelter, include the value of the ISM as income for the month the payment is made.

NOTE: Include the ISM only in the month when the third party actually makes the payment, even though the individual may have received the food, clothing, or shelter in a previous month.

Rent Free Shelter

Rent free shelter is a type of ISM in the form of shelter provided by someone outside the household to a Medicaid individual/couple residing in LA-A.

NOTE: Shelter that is income in return for services is not rent free shelter.

SPECIAL CONSIDERATIONS

Rent Free Shelter (cont.)

Consider rent-free shelter to exist when no household member has ownership interest or rental liability for the dwelling in which the individual/couple lives.

NOTE: If there is an agreement to pay rent, consider rental liability to exist, even if the individual is not currently making rental payments.

The use of land alone is not rent free shelter.

Rental Subsidy

A rental subsidy is a type of ISM in the form of subsidized shelter provided by someone outside the household to a Medicaid individual/ couple residing in LA-A.

Develop rental subsidy only when any household member has rental liability and a household member is the parent or child of the landlord.

Determine the amount of rental subsidy as follows:

- Compare the current market rental value (CMRV) of the dwelling to the actual amount of rent paid under the rental agreement.
- If the rent paid is less than the CMRV of the dwelling, consider all household members to be receiving a rental subsidy.
- Pro rate the value of the rental subsidy (CMRV minus rent paid) among all members of the household, including members who are ineligible or temporarily absent.
- Include the Medicaid individual's pro rata share of the rental subsidy as ISM not to exceed the PMV.

Do **NOT** consider the following as a rental subsidy:

- public housing assistance which is supplied by a state agency based on need
- public housing assistance excluded by federal statute, such as a HUD subsidy
- rental subsidies excluded under a plan for achieving self-sufficiency (PASS)
- rent/mortgage payments made under the terms of a credit life or credit disability policy.

SPECIAL CONSIDERATIONS (cont.)

No ISM Charged

Do not charge ISM if a Medicaid individual/couple receives food, clothing, or shelter that meets any of the following criteria:

- It is specifically excluded by federal law, such as the Disaster Relief Act of 1974.
- It meets the criteria for exclusion of infrequent or irregular unearned income.
- It has no CMV.
- It is provided under a government (federal, state or local) medical or social service program.
- It is ABON from a state or one of its political subdivisions.
- It is food or shelter received at school by a child under age 22 who receives food or shelter only at school while temporarily absent from his/her parent's household.
- It is food or shelter received during a temporary absence.
- It is a replacement of a lost, damaged or stolen resource in the form of food, clothing, or shelter, including temporary housing.
- It is provided by someone living in the same household whose income is subject to deeming to the individual.

NOTE: ISM received by a deemor is not deemed to the Medicaid individual.

Food, Clothing, Shelter Which is Remuneration for Work

Refer to Section 2405, Treatment of Income, for a discussion of the treatment of food, clothing, or shelter which is remuneration for work.

DOCUMENTATION

Document the ISM1 screen in the system.

2499 – TREATMENT OF INCOME IN MEDICAID

Use the chart below to determine the following treatment for a specific type of income:

- whether the income is included (I) or excluded (E) in the Medicaid eligibility budgets for ABD and Family Medicaid and patient liability/cost share budgets
- whether the income is earned or unearned
- specific verification requirements, if any.

NOTE: If specific verification requirements are not listed, verify the income from the source.

CHART 2499.1 – TYPES OF INCOME IN MEDICAID

TYPE OF INCOME	DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ADOPTION ASSISTANCE	Unearned – money received for the adoption of certain children.		
IV-E	Consider as unearned income to the adopted child.	I	I
IV-B	Exclude as income.	E	E
ADVANCE	Unearned – Money for future expenses that does not represent a gain to the AU.	E	E
	Earned – A prepayment of wages or salaries.	I	I
AGENT ORANGE PAYMENTS	Unearned – payments to Vietnam vets exposed to Agent Orange defoliant and their surviving spouse and/or children.	E	I
ALASKA NATIVE CLAIM	Unearned – Payments made under Alaska Native Claims Settlement Act.	E	I
ALIMONY/ SPOUSE SUPPORT	Unearned – payment from an estranged spouse	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
AMERICORPS	Income from Americorps Network of programs which encompasses: Americorps USA Americorps VISTA Americorps NCCC Are handled as specified below:		
	Living Allowance Stipend – Earned Income	E	E
	On-the Job Training – Earned Income	E	E
ANNUITY	Unearned – Recurring payment received from an investment. Refer to Section 2339, Trust Property, Annuities.	I	I
ASSISTANCE BASED ON NEED (ABON)	Unearned – assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a state or local government.	E	E
BLACK LUNG BENEFITS	Unearned – benefits paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act.	I	I
BLOOD, sale of	Earned – Money received from the sale of blood including blood products.	I	I
BOARDER INCOME	Earned – Direct payments for food and related shelter expenses, less the cost of doing business.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
BONUS	Earned – Refer to Wages/Salaries in this chart.	I	I
CAPITAL GAINS	Earned or Unearned – profits from the sale of capital goods or equipment. Capital assets are resources such as stock, securities, real estate and equipment that are typically held as an investment for a period of time. A capital gain is realized when the item(s) sold have appreciated in value from the original purchase price.	I	I
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGAINZATION NOT STATE/ FEDERALLY FUNDED	Unearned – Charitable donation paid to the AU or BG.	E	E
CHARITABLE DONATION FROM FEDERALLY OR STATE FUNDED ORGANIZATION	Unearned – Charitable donation paid to the Au or BG.	I	I
CHILD CARE ATTENDENT (wages earned by)	Earned – income received for providing child care services. Consider the income as follows: • Self-employment if the attendant provides child care services in his/her home • As wages if the attendant provides services in the home of the child	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
CHILD CARE PAYMENTS	Unearned – child care payments made under Title IV of the Social Security Act, including Transitional Child Care. *At Risk* block grants, child care payments made under section 5801 of the Social Security Act.	E	E
CHILD NUTRITION PAYMENTS	Unearned – The value of meals provided to a child in day care through the Child Nutrition Amendment of 1978. If the payment is for a child of the attendant, budget the entire amount as unearned income. If the payment is for any other child, treat as self-employment income. Refer to the Section 2420, Self Employment.	*I	I
CHILD SUPPORT	Unearned – income received for the support of child(ren) from the non-custodial parent of the child. Child support paid for a child by a non-custodial parent is always income to the child and never to a parent/ relative/ guardian. *If an ABD Medicaid child receives child support, exclude from the eligibility budget 1/3 of the monthly child support received. *If a Family Medicaid child receives child support, exclude $50. If a deemor (spouse or parent of the A/R) is an absent parent and makes court ordered or IV-D (OCSR) child support payments to a child outside of the home, exclude these payments from deeming. This exclusion does not apply to an A/R who is an absent parent. Verify through CSE, probation office or the parent making the payments.	*I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
CHILD'S EARNINGS	Earned – Income earned by a child, including RSM 18 year olds and for CW-FC children to 21 years is excluded.	ABD – I FM - E	E
CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS	Unearned – income paid by the U.S. Civil Service and Federal Employee Retirement System (FERS) through the Office of Personnel Management (OPM) because of disability, retirement or death. **NOTE:** Certain disability benefits paid within the first 6 months that an employee last worked are earned income. Use notices or other documents in the individual's possession (other than a check) to verify the gross amount of the payment. Notices providing the amount of the annuity and the adjusted amount of the annuity are reliable evidence of the gross amount. If an individual's records are unavailable, complete Form 990, Benefits Verification, and direct the inquiry to the following address: Office of Personnel Management Retirement and Insurance Coverage 1900 E. Street, NW Washington, D.C. 20415	I	I
COMMISSION	Earned – Refer to *Wages/Salaries* in this chart.	I	I
CONTRACTED EMPLOYMENT INCOME	Earned – Income earned over a period of more than one month prorated over the number of months in which it is earned.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
CONTRIBUTION, GIFT, PRIZE, AWARD	Unearned – money given to the A/R as a gift from individuals or organizations. *For ABD Medicaid, if the contribution is in the form of food, clothing or shelter, value the contribution as ISM, including third party vendor payments resulting in food, clothing, or shelter to the A/R. **EXCEPTION:** Never include ISM as income for an A/R in LA-D.	*I	I
DEATH BENEFITS	Unearned – a benefit received as the result of another's death, such as the following: • Cash or in-kind gifts given by relatives, friends, or a community group to "help out" with expenses related to the death • Inheritances in cash or in kind • Lump sum death benefits from SSA • Proceeds of life insurance policies received due to the death of the insured • RR Retirement burial benefits • VA burial benefits **NOTE:** Recurring survivor benefits such as those received under Title II (RSDI), private pension programs, etc., are not death benefits. * Death benefits provided to an individual are income to the individual to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the individual. Last illness and burial expenses include related hospital and medical expenses; funeral, burial plot, and interment expenses; and other related expenses.	*I	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
DEATH BENEFITS (cont.)	Verify all last illness and burial expenses. If verification (e.g., bills, receipts, contact with provider, etc.) cannot be obtained, accept the individual's signed allegation. If an expense has been incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No follow-up is required if the assumption is applied. Use judgement to determine whether an expense is reasonably related to the last illness and burial. It is expected that related expenses may include such items as new clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc.		
DEEMED INCOME	Unearned – A portion of income of a non-AU or BG member that is applied to the AU. * For ABD Medicaid, there is no deeming in Patient Liability/Cost Share determinations.	I	*
DISABILITY OR SICK PAY	Unearned – Paid by insurance company or a source other than an employer. Refer to Sick Pay in this chart.	I	I
DISASTER ASSISTANCE (Presidentially Declared)	Unearned – Government payments for restoration of a home damaged by a disaster.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
DIVERTED INCOME FOR ABD MEDICAID	Unearned - Income diverted to a spouse or dependent family member from a NH or CCSP A/R.	I	I
Spouse or Dependent Family Member	Include as unearned income to the spouse or dependent family member (DFM) to whom the income is diverted in the eligibility and CCSP/ICWP cost share budgets, if the spouse /DFM is a Medicaid A/R. Refer to Section 2554, Diversion of Income.		
A/R	Include as unearned income to the A/R from whom the income is diverted in the eligibility budget. Allow as a patient liability/cost share budget deduction. Verify from the NH, CCSP or A/R's case record. **EXCEPTION**: Diverted income is included in PL when a community spouse enters LA-D. Refer to Spousal Impoverishment budgeting.	I	E
DIVERTED INCOME FOR FAMILY MEDICAID	Unearned – Money deducted or diverted by a court order to a third party.	E	N/A
	Unearned – Money that is legally obligated to an AU member by a court order but is diverted at the option of the AU member to a third party.	I	N/A
DIVIDENDS	Unearned – A share of profits received by a policy holder or shareholder. **NOTE:** Any dividends left to accrue are a resource separate from the resource that is earning dividends. For ABD Medicaid, dividends earned on life insurance policies are excluded as income. **NOTE:** Non-participating life insurance policies do not earn/pay dividends. Use Form 106 or other acceptable documents to verify dividends.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
DOMESTIC VOLUNTEER SERVICES PAYMENTS/ ACTION	Unearned – Payments to volunteers under the federal government program	E	I
EARNED INCOME TAX CREDIT (EITC)	Unearned – A special tax credit which reduces the federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment. EITC payments can be received as an advance from an employer or a refund from IRS. EITC given as a tax credit (no payment) is not income.	E	I
EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS	Unearned – payments from educational assistance to the A/R. Include any portion used for food, shelter, or clothing. * Exclude amounts used to pay tuition, fees and miscellaneous educational expenses such as transportation, books, lab fees, etc.	ABD -*I FM - E	*I
EMERGENCY ASSISTANCE (IV-A)	Unearned – payments for children, including families with children, provided by the state and matched with federal funds. Emergency Assistance is used to meet emergency needs and is not IBON or ABON. **NOTE:** Georgia does not provide Emergency Assistance payments.	I	I
EMPLOYEE RETIREMENT BENEFITS	Unearned – Individuals/surviving spouse may be eligible for retirement benefits based on previous employment. Explore if the A/R or spouse worked 10 or more years for the same employer.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
ENERGY ASSISTANCE PAYMENTS	Unearned – Payment or allowance received under federal, state, and local law for utility expenses including HUD and FMHA Utility reimbursements.	E	E
FARM ALLOTMENTS	Unearned – Payments from government sponsored programs such as Agricultural Stabilization and Conservation Services which are a gain or a benefit.	I	I
FARMING	Earned – Income received from agricultural labor. Refer to the Section 2420, Self Employment.	I	I
FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS	Unearned – food and shelter assistance provided in cash or in kind in emergency disaster situations. Exclude if the assistance is designated as home energy assistance or support and maintenance assistance. Otherwise, contact the State Medicaid Unit for further instructions.	E	E
FEDERAL PROGRAMS, MISCELLANEOUS	• Federal Housing Assistance • Food Stamps • Food Programs with federal involvement for Older Americans • Refugee Cash Assistance, Cuban and Haitian • Entrant Cash Assistance and federally reimbursed general assistance payments to refugees • Refugee reception and placement grants and refugee matching grants • Relocation Assistance **NOTE:** Contact the State Medicaid Unit if there is a payment that is not on this list and it is questionable as to whether it should be excluded or counted.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
FLEX BENEFIT	Earned – Refer to *Wages/Salaries* in this chart.	I	I
FOSTER CARE PAYMENTS (IV-B or Title XX)	Unearned – per diem payments received by the foster parents to provide for the needs of the foster child and foster family.	E	E
FOSTER CARE PAYMENTS (IV-E)	Unearned – per diem payment received to provide for the needs of the foster child. Include as income to the foster child.	I	I
FOSTER GRANDPARENTS PROGRAM PAYMENTS	Unearned – payments received for voluntary service under the federal government (ACTION)	E	I
GARNISHMENT	Earned/Unearned – Wages/monies withheld by an employer/entity and paid to a third party for an AU's expenses.	I	I
GENERAL ASSISTANCE (GA) PAYMENTS	Unearned – payments received by the A/R from county funds administered by DFCS. Consider as Assistance Based on Need (ABON).	E	E
GENERAL ASSISTANCE VENDOR PAYMENTS	Unearned – GA paid directly to the provider if paid for housing expenses including GA paid for transitional housing for the homeless and if paid for energy or utilities.	E	E
GERMAN REPARATION PAYMENTS	Unearned – payments made under the Republic of Germany's Federal Law for Compensation for Nationalist Socialist persecution to certain survivors of the Holocaust. Payments may be made periodically or as a lump sum. Refer to the Chapter 2300, Resources for lump sum information.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
HOME PRODUCE	Unearned – home produce used for personal consumption and not offered for sale.	E	E
HOUSING AND DEVELOPMENT (HUD) RENTAL REFUND	Unearned – Payment received by the AU for rent. Payments are often distributed by the Georgia Residential Financial Authority (GRFA). Payments can be made directly to the AU, by a two-party check or directly to the landlord on behalf of the AU.	E	E
HOUSING AND URBAN DEVELOPMENT (HUD) OR FARMERS HOME ADMINISTRATION (FMHA) UTILITY REIMBURSEMENT	Unearned – Utility reimbursement provided by HUD and FMHA to AUs who receive housing assistance and are responsible for paying their utilities separately from their rent. Payments can be paid directly to the AU, by a two-party check or directly to the utility company on behalf of the AU.	E	E
INCOME BASED ON NEED (IBON)	Unearned – Assistance provided under a program that considers other income as a factor in determining eligibility and is funded wholly or partially by the federal government or a non-governmental agency for the purpose of meeting basic needs (TANF, SSI, VA Pension, etc. **NOTE FOR ABD:** Do not allow the $20 general exclusion to IBON. Do not deem IBON received by the A/R's spouse or parent to the A/R.	E	I
INCOME TAX REFUND	* Refer to the Chapter 2300, Resources to determine how to count income tax refunds	*	*
INDIAN LAND GRANTS	Unearned – Federal distributions to members of Indian Tribes.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGI-BILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
INHERITANCE	Unearned – cash, a right or a non-cash item(s) received as a result of someone's death. Exclude expenses for the last illness and burial of the deceased if paid by the inheritor. **NOTE:** Until an item or right has a value or is accessible, it is neither income nor a resource.	I	I
IN-KIND ITEMS RECEIVED IN LIEU OF WAGES	Earned – wages may include the value of food, clothing, shelter or other items provided in lieu of cash wages.	ABD – I FM – E	E
IN-KIND SUPPORT AND MAINTENANCE	Unearned – Any gain or benefit that is not in the form of money payable directly to the AU such as meals, clothing, produce or housing. * Refer to section 2430, Living Arrangements and In-Kind Support and Maintenance.	ABD - *I FM – E	E
INSURANCE BENEFITS DUE TO LOSS OF INCOME	Unearned – benefits paid from an insurance policy due to loss of income. * Refer to Section 2230, Third Party Resources, for information on benefits paid to cover medical expenses.	*I	*I
INTEREST	Unearned – income paid from bank account deposits, life insurance or other financial instruments/investments. **FAMILY Medicaid:** Annualize for prospectively and anticipated income budgeted AUs to determine a monthly amount. **Exclude** amounts of $1.00 or less per month.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
INTEREST (cont.)	**ABD Medicaid:** The following types of interest are included in the eligibility budget if they exceed $20 per month: • Interest earned on all financial instruments, such as checking/savings accounts, CDs, etc. • Interest earned on Patient Fund Accounts. **NOTE:** If total interest earned is $20/month or less, exclude in the Medicaid eligibility and AMN spenddown budgets. If total interest exceeds $20/month, include all the interest in the eligibility and spenddown budgets.	I	I
INTEREST Burial Contracts	Exclude interest earned on the excluded portion of a burial contract for FBR A/Rs.	E	E
	Exclude all interest earned on a burial contract for non-FBR A/Rs if left to accrue.	E	E
Burial Funds	Exclude interest earned on the excluded portion of funds set aside for burial for FBR A/Rs.	E	E
	Exclude interest earned on the first $5000 of funds set aside for burial for non-FBR A/Rs if left to accrue.	E	E
INTEREST Dividends	Exclude interest earned on the dividend accumulations from excluded life insurance policies for ABD Medicaid non-FBR A/Rs.	E	E
	Include dividends earned on countable resources such as stocks and mutual funds.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
IRREGULAR INCOME	Earned and Unearned – Income that is received too infrequently or irregularly to be anticipated, regardless of the amount, such as the following:		
	• Irregular income	I	I
	• Income of $30 or more received over a three month period	I	I
	• Income of less than $30 received over a three month period	I	I
JAPANESE – AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS	Unearned – Restitution payments made by the U.S. Government to Japanese-Americans and Aleutians or their survivors who were interned or relocated during World War II.	E	E
JURY DUTY	Earned – Compensation received for serving on a jury.	I	I
LOANS (PERSONAL OR BUSINESS)	Unearned – Money received that the borrower has an obligation to repay. Requires a prepayment agreement (written or oral). * **ABD Medicaid:** Refer to Section 2313, on how to count.	E	*
LOTTERY WINNINGS	Unearned – A sum of money received as a result of purchasing a winning ticket in a game of chance. * Refer to the appropriate sections on Lump Sum budgeting for Family Medicaid or ABD Medicaid.	*	*

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
LUMP SUM	Unearned – A sum of money that is received at one time. This may be an accumulated amount or a one-time occurrence. * Refer to the appropriate sections on Lump Sum budgeting for Family Medicaid or ABD Medicaid.	*	*
MANAGED INCOME	Unearned – Money legally due the AU that is paid to a protective payee even if the payee is not a member of the AU or resides elsewhere. ********** Unearned – Money received by the AU for the care and maintenance of an individual not in the AU. Include as income to the individual entitled to the income. Exclude as income to the protective payee. **NOTE:** Exclude as income to the AU if the protective payee is not making payments to or for the AU.	ABD – I FM – I ********** ABD – I FM – I	I ******** * I
MILITARY ALLOTMENTS	Unearned – payments received for quarters, rations, and clothing are subject to deeming. In ABD Medicaid, Furnished on-post housing is subject to the PMV rule as ISM but is not subject to deeming. In Family Medicaid, consider the income as child support if for a dependent child. Only base pay is earned income.	I	I

2499.1 - TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
MILITARY PAY	Military personnel benefits as reported on Leave and Earnings Statement (LES). Refer to Section 2451, Military Pay.	I	I
MILITARY RETIREMENT	Unearned – income received by military retirees and survivors. Beneficiaries who may be entitled to receive military payments include the retiree, his/her surviving spouse and children. Direct inquiries to :the Military Finance Centers as shown below: Air Force: Parallel FO: 388 AFAFC/XSP Denver, CO 80279 Army: USAFAC Director, Retired Operations Indianapolis, IN 46246 ATTN: Management Support Office Marine Corps: Parallel FO: D24 Marine Corps Finance Center 1500 E. 95th Street Kansas City, MO 64197 Navy: Parallel FO: D24 Retired Pay Department Code 305, Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199	I	I
MILITARY RETIREMENT LUMP SUM	Unearned – Consider as unearned income in the month or receipt. Treat as a resource the month following the month of receipt.	I	I
NOISE ABATEMENT PAYMENTS	Unearned – Non-recurring payment designated for noise abatement work on a dwelling.	E	E
OLDER AMERICANS ACT/ SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM	Earned – Title V income paid for community service employment to individuals 55 or over. This includes *Green Thumb* income. Anything provided under these programs other than a wage or salary is excluded income.	ABD - I FM - E	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
OVERTIME	Refer to *Wages/Salaries* in this chart.	I	I
PENSIONS	Unearned – A sum of money paid regularly as a retirement benefit.	I	I
PUBLIC LAW 103-286	Unearned – Payments to individuals received as a result of their status as victims of Nazi persecution.	E	E
RAILROAD RETIREMENT (RR)	Unearned – retirement, survivors or disability income paid to former railroad employees and /or their dependents. Use gross RR and/or RSDI, including the amount paid as a Medicare premium. * For ABD Medicaid, refer to Section 2552, Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget. Consider a benefit augmented for dependents as income to the beneficiary, not the dependent. If the A/R's SSN begins with a 7, the individual is likely to be eligible for RR. If the A/R's deceased spouse worked for a railway system, the A/R may be eligible, even if remarried. RSDI and RR may be combined in one check. If so, verify RSDI via SSA and RR through the Railroad Retirement Board. To obtain written verification of the benefit amount, complete Form 990 and mail to: Benefits Verification Railroad Retirement Board 401 W. Peachtree Street, Room 1702 Atlanta, GA 30365-2550	I	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
REFUNDS FROM DMA	Unearned – A refund of excess proceeds from a TPR after Medicaid and the TPR have paid a medical expense claim in full.	I	I
REIMBURSEMENT	Payment for past expenses that does not represent a gain or benefit to the AU.	E	E
RELOCATION ASSISTANCE	Unearned – Money paid under Title II of the Uniform Relocation Assistance & Real Property Acquisition Policies Act of 1970.	E	E
RENTAL INCOME	Earned or unearned – Money received from property owned and rented to others. Earned – Must be engaged in management of property an average of 20 hours per week. Unearned – If not involved in management more than 20 hours per week.	I	I
REPAYMENT OF OVERPAYMENT OF BENEFITS THROUGH BENEFIT REDUCTION IN TANF, SSI, RSDI, UCB (or others)	FAMILY MEDICAID: Unearned – Money withheld from the income source to repay a previous overpayment. Exclude the amount withheld in determining the income amount to consider. * ABD MEDICAID: Refer to RSDI Recoupment Amount and SSI Recoupment Amount in this chart.	FM – E ABD - *	*
RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)	Unearned – A federal volunteer services program.	E	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
RETIREMENT	Unearned – A sum of money paid regularly as a retirement benefit.	I	I
RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI) (Also referred to as TITLE II BENEFITS or Social Security Benefits)	Unearned – Social Security benefits paid to an insured worker or dependent on the basis of the retirement, death or disability of the worker. Use the gross entitlement (before the Medicare Part B premium is deducted) in the eligibility budget. * For ABD Medicaid, refer to Section 2552, Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget. Count the entire RSDI lump sum payment as income for the month of receipt. **NOTE:** Refer to Chart 2399.2 – Resource Treatment of Income Retained after the Month of Receipt, for instructions on how to treat any portion of a RSDI lump sum retained after the month of receipt. **Do not count refunded Medicare Part B premiums as unearned income.**	I	*I
REVERSE MORTGAGE	Unearned – allows a homeowner to borrow, via a mortgage contract, a portion of the appraised value of the home. The homeowner then receives a periodic payment (or a line of credit) which does not have to be repaid as long as the borrower lives in the home. Reverse Annuity Mortgages (RAMs) involve the purchase of an annuity. In most reverse mortgages, the original loan does not need to be repaid until the homeowner dies, sells the home, or moves. The HEC plans connected with HUD through the Federal Housing Authority are reverse mortgages. Treat as loan proceeds Annuity payments from a RAM	E I	E I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
ROOMER	Earned – Direct payments for room only.	I	I
RSDI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly RSDI check by SSA to recover an overpayment of RSDI benefits to the individual *Refer to Repayment of Overpayment of Benefits on Page 2499-19.	ABD – I FM – E*	E
SALE – LEASEBACK	Unearned – the homeowner transfers title of the home to a buyer (e.g., an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. The difference between payments on the installment note and the rental cost provides the former homeowner with cash. Under this arrangement, the buyer is responsible for the payment or real estate taxes, major maintenance, and casualty insurance. Some sale-leaseback arrangements involve the purchase of an annuity.		
	Treat as the conversion of a resource, not as income.	E	E
	Interest earned from an installment note	I	I
	Annuity payments	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
SELF EMPLOYMENT EARNINGS (NET)	Earned – income from a self employed enterprise.	I	I
SENIOR COMPANION PROGRAM	Unearned – payments to volunteers under a federal government program	E	I
SEVERANCE PAY	Earned – Money received from former employer upon termination of employment.	I	I
SHARED HOUSEHOLD EXPENSES	Payments for shared household expenses made to an A/R. Consider **UNEARNED** income for Family Medicaid. Refer to Section 2415, In-Kind Support and Maintenance, for ABD Medicaid.	E	E
SHELTERED WORKSHOP / WORK ACTIVITY CENTER PAYMENTS	Earned – payments received for work performed in a sheltered workshop or work activity center.	I	I
SICK PAY	Sick Pay is a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability. Unearned – Any payments for sickness and accident disability paid more than 6 months after work stopped because of sickness or disability or sick payments made from the employee's own contributions are unearned income. Earned – If paid from employer's payroll.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
SOCIAL SECURITY BENEFIT (RSDI)	Unearned – Retirement, Survivor, and Disability Insurance benefits administered by the Social Security Administration.		
SPECIAL AND DEMONSTRATION VOLUNTEER PROGRAMS	Unearned – Payments to volunteers under a federal government program	E	I
STRIKE BENEFITS	Unearned – Income received by individuals on strike.	I	I
SUPPLEMENTAL SECURITY INCOME (SSI)	Unearned – monthly payments made to aged, blind or disabled individuals from the federal government. SSI is administered by the Social Security Administration. Consider as Income Based on Need (IBON). SSI recipients also receive Medicaid. * For ABD Medicaid, do not deem the ineligible parent or spouse's SSI income to the A/R. However, include SSI in the Couple eligibility budget when one member of the couple is AMN and the other receives SSI. ** Refer to Section 2578, SSI Recipients, for information on including SSI income in nursing home patient liability budgets.	ABD-*1 FM – E	**I
SSI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly SSI or RSDI check by SSA to recover an overpayment of SSI benefits to the individual. • Exclude a SSI recoupment from a SSI check, but include a SSI recoupment from an RSDI check, in the patient liability budget. For Family Medicaid, refer to *Repayment of Overpayment of Benefits through Benefit Reduction in TANF, SSI, RSDI, UCB or others* on page 2499-19.	ABD – I FM – E	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
SUSAN WALKER VS BAYER CORPORATION SETTLEMENT PAYMENTS	A cash settlement as a result of a class action lawsuit. Unearned	E	E
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments. TANF benefits received from another state are budgeted for the month of receipt only. *For ABD Medicaid, do not deem TANF income of the A/R's parent or spouse to the A/R.	ABD – I* FM - E	I
TAX REFUNDS	A refund of taxes paid on food, income or property.	E	I
Income	Earned – A refund of federal or state taxes paid on income.	E	E
Food or Property	Unearned – A refund of taxes paid on food or property, such as real property or automobiles.	E	E
TIPS	Earned – Refer to *Wages/Salaries* in this chart.	I	I
TRAINING ALLOWANCES/ STIPENDS (Refer to WIA for treatment of WIA income)	Earned – Allowances from vocational/ rehabilitation programs recognized by Federal, State, local governments to the extent they are not a reimbursement or specifically excluded. **NOTE:** If the earnings belong to a child, refer to *Child's Earnings* in this chart.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
TRUST PROCEEDS	Unearned – Money in a trust fund. * If the trust is not a Medicaid Qualifying Trust (MQT), include as income only those trust proceeds actually provided to the A/R by the trustee. * If the trust is an MQT, refer to Section 2336, Trust, Medicaid Qualifying, for information on how to treat the trust proceeds. Verify by a copy of the trust document and contact with the trustee.	 *I *I	 *I *I
UNEMPLOYMENT COMPENSATION BENETFITS (UCB)	Unearned – Benefits received from the Department of Labor (DOL) by unemployed individuals. Usually received weekly. Continue to count until notified by the A/R of termination. Use DOL Clearinghouse for verification of the amount and date of weekly benefits.	I	I
UNION FUNDS	Unearned – Refer to *Strike Benefits* in this chart.	I	I
UNIVERSITY YEAR FOR ACTION (UYA)	Unearned – payments received under a federal volunteer services program.	E	I
UTILITY PAYMENT (HUD SECTION 8/GRFA/FMHA)	Unearned - *Refer to *Housing and Development (HUD)* in this chart.	*	*
VACATION PAY	Earned – Refer to *Wages/Salaries* in this chart.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
VENDOR PAYMENT	Unearned – Money paid by an outside source to a third party of behalf of the AU. Housing assistance payments made by a state or local government to a third party on behalf on an AU residing in transitional housing for the homeless. **NOTE:** If the vendor payment is made with GA funds, refer to *General Assistance Vendor Payments* in this chart. **NOTE:** For ABD Medicaid, consider possibility of ISM. Refer to Section 2430.	E	E
VETERANS ADMINISTRATION (VA) BENEFITS	The following individuals are potentially eligible for VA benefits: • Any veteran • Child or spouse of a disabled or deceased veteran • Unmarried widow(er) of a deceased veteran • Parents of a veteran who died before 1/1/57 from a service-connected cause. Use Form 970 to verify the type and amount of VA benefits and send to: Department of Veteran's Affairs Atlanta Regional Office P.O. Box 100021 Decatur, GA 30031-7021		
VA Pension	Unearned – VA pensions are benefits paid to an aged, blind, or disabled veteran and/or dependents who are in need. **NOTE:** VA pensions are not military retirement. VA pensions are IBON and are not entitled to the $20 general exclusion.	I	I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
VA Pension (cont.)	The maximum monthly pension benefit for a veteran in a nursing home with no dependents is the same as the personal needs allowance (PNA) allowed in the patient liability budget. Refer to Appendix A1 for the current PNA.	I	I
VA Compensation	Unearned – VA compensation is a benefit paid to veterans/dependents who have a military related injury/disability or death. VA compensation is not IBON. **EXCEPTION:** Compensation received by parents due to the service connected death of their child is IBON.	I	I
VA Educational Benefits	Unearned – If the benefit or any portion of the benefit is one of the following, exclude that portion: • Paid under a VA program of vocational rehabilitation • Paid from the veteran's own contributions • Paid as an augmentation for a dependent.	ABD – I FM – E	E
Other VA Benefits Which are NOT Included As Income in the Eligibility Determination	Aid and Attendance – medical benefits paid to veterans or dependents. It is never included as income in the eligibility budget, or AMN spenddown budget. Unusual Medical Expense (UME) reimbursement – a reimbursement paid to some veterans for high medical costs. VA takes into account Medicaid payments and reduces UME payments accordingly. Housebound – A benefit to pay for an attendant for some housebound veterans/dependents. Clothing Allowance – benefits paid to some veterans with a service connected disability who use prosthetic or orthopedic appliances.	E E E E	E E E E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
Augmented VA Benefits	Unearned – An increase, or augmentation, of VA benefits to meet the needs of the beneficiary's (veteran's) dependent(s). **NOTE:** Any portion of a VA check augmented for dependents is income to the dependent(s). If the A/R is the beneficiary (payee) of an augmented VA check, exclude as income to the A/R any portion augmented for dependents. If the A/R is a dependent of a beneficiary and the beneficiary's check includes an augmentation for the A/R, count the augmented portion as income to the A/R if the A/R lives in the same household as the beneficiary. If the A/R lives apart from the beneficiary and the beneficiary does not give the A/R his/her augmented portion, use the following procedures: • Count the augmented portion of the beneficiary's check as income to the A/R for eligibility. • Require the A/R to apply for an apportionment (his/her own check). • Continue to count the augmentation as income for eligibility until VA denies apportionment. • If VA approves apportionment, include the apportionment as unearned income.	*I	*I

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
Augmented VA Benefits To NH/CCSP A/Rs	* If the A/R is in a nursing home and the beneficiary refuses to give the A/R his/her augmented portion of the VA benefit, require the A/R to apply for an apportionment. * If the A/R is not receiving his/her augmented portion, do not include the augmented portion in the patient liability/cost share budget. Continue to include the augmented portion in the eligibility budget until VA approves or denies apportionment. **NOTE:** Augmented VA benefits are treated differently than augmented RR benefits. The entire amount of an augmented RR check is income to the beneficiary.	*I	*E
VA Lump Sum	Unearned – A lump sum VA check received to cover several months of benefits. * Any portion of a VA lump sum that is not VA Aid and Attendance, is not VA UME reimbursement or is not augmented is counted as unearned income for the month of receipt.	*I	I
VICTIM RESTITUTION	Unearned – Money received by a victim of a crime from a crime victim restitution program, usually a reimbursement for financial losses. **EXCEPTION:** Include as income in the month of receipt only if it presents a gain above the dollar value of the replacement cost of property or it is a set monthly amount based on a court ruling.	E	E
VISTA	Earned – Income received by VISTA volunteers.	E	E

CHART 2499.1 – TYPES OF INCOME IN MEDICAID			
TYPE OF INCOME	**DESCRIPTION/SPECIAL INSTRUCTIONS/VERIFICATION**	**ELIGIBILITY - FAMILY OR ABD**	**PL/CS FOR ABD**
VOLUNTEER PAYMENT RSVP Foster	Unearned – Title II of Domestic Volunteer Services Act of 1973	E	I
Grandparent/ VISTA Urban Crime Prevention	Unearned – Payments from Title I. Exclude only if the A/R was receiving FS or AFDC at the time they joined Title I even if there is a break in participation.	E	I
WAGES (SALARIES)	Earned – gross income received from work for services rendered. Includes tips, overtime, vacation pay, bonuses, flex time/benefits. Refer to Section 2410, Earned Income.	I	I
WORKFORCE INVESTMENT ACT	Earned – Income received while working as part of a WIA program.	I	I
WORK STUDY PROGRAM	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	E	N/A
WORKER'S COMPENSATION	Unearned – payments awarded to injured employees or to their survivors. Exclude any portion designated for medical, legal, or related expenses paid or deducted and not controlled by the A/R in connection with claim. Verify from the employer or from the source of the payment.	I	I
YOUTH PROJECT PAYMENTS	Unearned – Payments made through projects developed to assist youth in acquiring work skills including the following: • Youth incentive entitlement pilot project • Youth community conservations and improvement projects • Youth employment *See WIA for treatment of this income.	*	*

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2500 – ABD FINANCIAL RESPONSIBILITY AND BUDGETING OVERVIEW

POLICY STATEMENT

Financial responsibility implies that a parent or spouse's income and resources are available to the Medicaid A/R as long as the A/R and the parent or spouse lives together in the same household.

Eligibility budgeting is the process in determining the A/R's income eligibility for ABD Medicaid by applying allowable deductions to the countable income of the A/R and financially responsible person.

BASIC CONSIDERATIONS

The following factors must be taken into consideration in order to determine whether to consider the income and resources of persons other than the A/R, the correct budget to be completed and the correct income limit to use:

- the A/R's living arrangement (LA)
- the adult A/R's marital relationship
- the financial responsibility of the A/R's spouse or parent
- the class of assistance under which the ABD Medicaid application will be processed.

PROCEDURES

Follow the steps below to determine financial responsibility and income eligibility for ABD Medicaid by completion of the correct eligibility target.

Step 1 Determine the A/R's LA, class of assistance and the financial responsibility of the A/R's spouse or parent(s).

- Refer to Section 2430, Living Arrangements and In-Kind Support and Maintenance, for procedures on determining the A/R's LA.
- Refer to Chapter 2100, Classes of Assistance, for procedures on determining the COA most advantageous to the A/R.
- Refer to the Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on the following:
  - When to include the income of the A/R's spouse or parent in the budget.
  - The correct budgeting procedures for determining income eligibility.

PROCEDURES (cont.)

- If the A/R is an adult, determine if the A/R is currently in a marital relationship. Refer to Section 2501, Marital Relationship.

- If the A/R is a child under age 18 living with his/her parent(s) in LA-C, refer to Section 2502, Deeming, for procedures on considering the income and resources of the parent(s).

Step 2 Determine countable income to be included in the eligibility budget. Refer to Section 2504, Determining Countable Income.

Step 3 Enter income in the system, allowing the correct deductions and income limit for the A/R's LA and COA to be appropriately applied in the budgeting process.

- Refer to Section 2505, Income Deductions, for information on deductions allowed in the eligibility budget.

- Refer to Appendix A for current income limits.

2501 – MARITAL RELATIONSHIP

POLICY STATEMENT	The A/R's marital relationship must be established to determine whether or not to consider the income and resources of a person other than the A/R.
BASIC CONSIDERATIONS	
Marital Relationship (Prior to 1/1/97)	A marital relationship exists for a man and a woman who are legally married or living together, free to marry and holding out (common-law) to the community as married. The common–law marriage must have existed prior to 1/1/97 to be recognized as a marital relationship.
Marital Relationship (On or after 1/1/97)	A marital relationship exists for a man and a woman who are legally married. A common-law marriage established on or after 1/1/97 is not considered a marital relationship in Georgia.
Marital Relationships established prior to 1/1/97 begins	A marital relationship begins to exist the month following the month two people marry or begin living together and holding out to the community as husband and wife. **EXCEPTION**: Use of the Spousal Impoverishment resource limit is limited to situations where an A/R in LA-D has a legal spouse in the community. See Section 2502 for definitions of legal and non-legal spouses.
Marital Relationship Ends	A marital relationship ceases the month following the month of separation of spouses, regardless or whether or not either or both is Medicaid eligible. The admission of one or both spouses into LA-D is considered separation. **EXCEPTION**: Admission of one spouse to a hospital is not always considered separation. Refer to Special Considerations in Section 2503, Couples. An A/R is considered an individual only if a marital relationship has ended, by definition above, or has never existed.

PROCEDURES

A marital relationship has ceased for an individual who is legally married but is living separately from his/her spouse due to estrangement (alienation, loss of affection, indifference). The spouse is not considered a community spouse for purposes of determining resource eligibility and patient liability.

Identify an adult A/R as one of the following:

- a Medicaid individual
- a Medicaid individual married to and living with a Medicaid individual (Medicaid couple)
- a Medicaid individual living with an ineligible spouse.

Medicaid Individual

Consider a SSI or ABD Medicaid A/R who is not currently in a marital relationship to be a Medicaid individual.

Consider only the income and resources of the Medicaid individual when determining his/her financial eligibility for ABD Medicaid. Use individual income and resource limits.

Medicaid Couple

Consider a SSI or ABD Medicaid A/R who is married and living with another SSI or ABD Medicaid A/R to be a Medicaid couple.

Refer to Section 2503, Couples, for information on considering the income and resources of a Medicaid couple.

Medicaid Individual With Ineligible Spouse

Consider a SSI or ABD Medicaid A/R who is married to and living with a spouse who is not a SSI or ABD Medicaid A/R to be a Medicaid individual with an ineligible spouse.

Refer to Section 2502, Deeming, for information on deeming the income and resources of an ineligible spouse.

2502 – DEEMING (ABD)

POLICY STATEMENT	Deeming is the process by which the income and resources of an ineligible spouse or ineligible parent are included in the budget to determine the A/R's financial eligibility for ABD Medicaid.
BASIC CONSIDERATIONS	The ineligible spouse of the A/R may be a legal, non-legal or community spouse. Non-legal marriages established on or after January 1, 1997 are not recognized as marriages in Georgia regardless of the ABD Medicaid Class of Assistance (COA).
Legal Spouses (Prior to 1/1/97)	A legal spouse is a member of a couple who has been married by legal ceremony or common-law. Under Georgia law, two individuals are in a common-law marriage if they live together at least one night, they are holding forth to the community as husband and wife, both are free to marry each other because neither is married to another person, and the relationship was established prior to January 1, 1997. Legality matters in relationships established prior to 1/1/97 only when the A/R is in LA-D or applies under an ABD Medically Needy COA.
Legal Spouses (On or after 1/1/97)	A legal spouse is a member of a couple who has been married by legal ceremony. This definition of a legal marriage is effective as of January 1, 1997. Common–law marriages established after this date are not considered legal. Legality matters in relationships established on or after 1/1/97 for all ABD Medicaid COAs.
Non-Legal Spouses	Non-legal spouses are holding out as husband and wife, but they are not free to marry each other. One or both has a legal spouse.
Community Spouse	A community spouse is the legal spouse (see two definitions above) of a Medicaid A/R in LA-D or AMN NH/Hospice. The community spouse may live in his/her own home (LA-A) or in someone else's home (LA-B).
Medicaid Child	A Medicaid child is a child living with his/her parent(s) who is a SSI or ABD Medicaid A/R.
Ineligible Child	An ineligible child is a child living with his/her parent(s) who is not receiving Public Assistance payments, such as SSI, TANF or VA pension, and is not applying for or receiving ABD Medicaid.
Ineligible Parent	An ineligible parent is the natural, adoptive or stepparent of the Medicaid child or ineligible child who is not a SSI or ABD Medicaid A/R. If the Medicaid child lives with the ineligible parent, a portion of the ineligible parent's income and resources may be considered in determining the child's eligibility for ABD Medicaid.

BASIC CONSIDERATIONS (cont.)

Deeming Begins

Spouse to Spouse Deeming begins the month following the month a marital relationship begins. Refer to Section 2501, Marital Relationship.

Parent to Child Deeming begins the month after a parent(s) and child begin living together in the same household (LA-A, B or C).

Deeming Ceases

Spouse to Spouse Deeming ceases the month following the month a marital relationship ends. Refer to Section 2501, Marital Relationship.

Parent to Child Deeming ceases the month following the month parents and their children cease living together in the same household (LA-A, B or C).

After an A/R ceases living with the financially responsible relative, only income actually made available to the A/R is considered in determining the A/R's financial eligibility.

EXCEPTION: If the responsible relative is temporarily absent from the home and is expected to return within the same month or the following month, consider the absent relative to be living with the A/R.

When one spouse (or child) enters LA-D, including AMN NH/Hospice, deeming of income ceases for the LA-D A/R the month of admission. Spousal impoverishment resource rules apply the month of admission. If the community spouse is an A/R under a non LA-D COA, deeming of income and resources ceases for the community spouse the month following the month of admission.

When both spouses enter LA-D, including AMN HN/Hospice, treat both A/Rs as individuals beginning the month of admission in determining income eligibility. For resource eligibility, treat both A/Rs as a couple the month of admission and as individuals the month following the month of admission.

EXCEPTION: Admission to a hospital does not terminate the hospitalized individual's financial responsibility for his/her spouse or child residing in the community. Refer to Special Considerations in Section 2503, Couples.

BASIC CONSIDERATIONS (cont.)

Resources Excluded From Deeming

Deemors are entitled to the same resource exclusions allowed to the A/R. Refer to Chapter 2300, Resources.

The following pension funds owned by an ineligible spouse or parent are not deemed to a non-institutionalized A/R:

- IRAs
- Keoghs
- Private pension funds.

The above pension funds owned by the community spouse of an institutionalized A/R are considered in the resource determination of the A/R.

NOTE: Private pension funds owned by the A/R are always considered in the resource determination.

Income Excluded From Deeming

The following types of income owned by an ineligible spouse or parent are not deemed to the A/R:

- Income Based on Need (IBON), such as the following:
  - SSI/TANF
  - IV-E payments
  - VA pension
  - Only VA compensation received by the parent(s) of a veteran who died from a service related cause prior to January 1, 1957.
- Any income used in determining the amount of an IBON payment.
- Portions of scholarships, grants, or fellowships used to pay tuition and/or fees
- Foster care payments for the care of an ineligible child
- Value of Food Stamps/commodities.
- Home produce for personal consumption
- Tax refunds
- Court ordered support payments made by a deemor

  NOTE: Support payments made by the A/R are not excluded.

- ISM received by a deemor or ineligible child
- Income otherwise excluded by federal statute
- Total earned income of an ineligible child if a student ($400/month, up to $1,620/year)

BASIC CONSIDERATIONS

Income Excluded From Deeming (cont.)

- Income necessary for a Plan to Achieve Self Sufficiency (PASS)
- Infrequent or irregular income of parents and spouses (one exclusion per marital relationship)
- Funds withdrawn from parent's retirement/pension fund (i.e. IRA) in the month of withdrawal.

  NOTE: Any funds remaining the month after the withdrawal are a resource.

Deeming Resources From an Ineligible Spouse to a Medicaid Individual in LA-A or B

Combine the resources of the Medicaid individual and his/her ineligible spouse and apply them to the appropriate couple resource limit.

If the combined resources do not exceed the couple resource limit, the A/R is eligible based on resources.

Deeming Resources from A Non-legal Ineligible Spouse to a Medicaid Individual in LA-D

If the Medicaid individual enters LA-D, has a non-legal ineligible spouse at home, and the non-legal marital relationship was established prior to 1/1/97, combine the resources of the Medicaid individual and his/her ineligible spouse and apply them to the SSI Couple resource limit only for the month of admission to LA-D. (If the non-legal marital relationship was established on or after 1/1/97, use the individual resource limit.)

Consider only the Medicaid individual's resources beginning the month following the month of admission to LA-D. Use the SSI Individual resource limit.

NOTE: If the A/R transfers resources to a non-legal ineligible spouse, apply a transfer of resources penalty. Refer to Section 2342, Transfer of Resources.

Deeming Resources when an A/R with a community Spouse enters LA-D

Follow the steps below to determine the resource eligibility for an A/R in LA-D or AMN NH/Hospice who has a community spouse for each prior month of Medicaid requested.

Prior Months Eligibility

Combine the countable resources owned by the A/R and the community spouse on the first day of the prior month and apply them to the Spousal Impoverishment resource limit.

If the combined resources are greater than the Spousal Impoverishment resource limit, the A/R is ineligible based on resources. Deny Medicaid for the prior month.

If the combined resources are less than or equal to the Spousal Impoverishment resource limit, the A/R is eligible based on resources for the prior month.

PROCEDURES (cont.)

Ongoing Eligibility

Follow the steps below to determine the ongoing resource eligibility for an A/R in LA-D or AMN NH/Hospice who has a community spouse:

Step 1

Combine the countable resources owned by the A/R and the community spouse on the first day of the month of application and apply them to the Spousal Impoverishment resource limit.

If the combined resources are greater than the Spousal Impoverishment resource limit, the A/R is ineligible based on resources. Deny the application.

If the combined resources are less than or equal to the Spousal Impoverishment resource limit, the A/R is eligible based on resources. Proceed to Step 2.

Step 2

Apply the countable resources owned by the A/R on the first day of the month of application to the SSI Individual resource limit.

If the resources owned by the A/R are less than or equal to the SSI Individual resource limit, the A/R continues to be eligible based on resources. Consider the ongoing resource eligibility determination for the A/R to be completed.

If the resources owned by the A/R exceed the SSI Individual resource limit, require the A/R to transfer his/her resources in excess of the SSI Individual resource limit to the community spouse or to a third party for the sole benefit of the community spouse by no later than the first annual review. Proceed to Step 3.

NOTE: See page 2502-8 for definition of "for sole benefit of" the community spouse.

Step 3

Require the A/R to declare in writing the resources s/he intends to transfer to the community spouse or to a third party for the sole benefit of the community spouse.

Step 4

Notify the A/R in writing of the type and value of resources s/he has declared and the requirement to transfer by the first annual review.

A/R Receives an Additional Resource Before the First Annual Review

If the A/R receives an additional resource between the initial determination of eligibility and the first annual redetermination, redetermine the A/R's resource eligibility.

PROCEDURES

A/R Receives an Additional Resource Before First Annual Review (cont.)

If the additional resource combined with other resources of the A/R does not exceed the SSI Individual resource limit, document the record that the A/R continues to be resource eligible without any further development.

If the additional resource combined with other resources of the A/R exceeds the SSI Individual resource limit, repeat Step 1 above, using the resources of the community spouse for the first day of the month of application and the current month's first day resources for the A/R.

Resource Eligibility Determination at First Annual Review

If the resources of the A/R are less than or equal to the SSI individual resource limit on the first day of the month of the first annual review, consider the A/R to remain eligible based on resources.

NOTE: Assume that the A/R transferred his/her countable resource in excess of the SSI individual resource limit to the community spouse unless questionable.

If resources of the A/R exceed the SSI individual resource limit on the first day of the month of the review, terminate Medicaid eligibility after giving timely notice.

A/R with a Community Spouse Receives an Additional Resource after the First Annual Review

Follow the steps below when a LA-D or AMN NH/Hospice Medicaid recipient with a community spouse receives a resource after the first annual review which, combined with other resources, causes the total countable resources of the A/R to exceed the SSI individual resource limit.

Step 1 Require the A/R to declare in writing the intent to transfer his/her resources in excess of the SSI individual resource limit to the community spouse or to a third party for the sole benefit of the community spouse.

Step 2 Allow the A/R 90 days from the date of receipt of the excess resource to transfer the resources to the community spouse.

Step 3 If the A/R transfers the resource within the 90 day grace period, consider the A/R to remain eligible based on resources.

If the A/R fails to transfer the resource within the 90 day grace period, terminate eligibility after giving timely notice.

NOTE: An individual can only be eligible using the Spousal Impoverishment resource limit one time. If a case is terminated at any point after 1 year due to excess resources, the SSI individual resource limit is used for all subsequent applications even though the A/R has a community spouse.

PROCEDURES
(cont.)

Use the following chart to assess a resource transfer made by a LA-D A/R with a community spouse:

CHART 2502.1 - RESOURCE TRANSFERS BY AN A/R WITH A COMMUNITY SPOUSE

IF	THEN
the A/R transfers a resource to the community spouse	Do not apply a transfer of resources penalty.
the A/R transfers a resource to someone else for the sole benefit of the community spouse	Do not apply a transfer of resources penalty. The transfer must be accomplished by a written document that legally binds the third party to a specified course of action, and which clearly states the condition of the transfer and who can benefit from the transfer. The transfer must be made so that no individual or entity can benefit from the transfer, either at the time of transfer or in the future, except the community spouse.
the A/R transfers a resource to someone other than the community spouse	Apply a transfer of resources penalty. Refer to Section 2342, Transfer of Resources.

Spouse to Spouse Deeming of Income

Complete Spouse to Spouse Deeming of Income on Form 172 when the A/R is a Medicaid individual living with an ineligible spouse in LA-A or B. Refer to Section 2507, Spouse to Spouse Deeming.

EXCEPTION: DO NOT deem the income of a spouse for any month eligibility is determined for an A/R in LA-D under a class of assistance that uses the Medicaid CAP as the income limit. Refer to Section 2510, Medicaid CAP Budgeting.

Deeming Resources from Ineligible Parent(s) to a Medicaid Child

If only one parent is living in the household with the Medicaid child, deem the parent's resources as follows:

- Subtract the Individual resource limit appropriate for the COA from the parent's countable resources.
- Deem the amount in excess of the Individual resource limit to the eligible child(ren).

PROCEDURES (cont.)

Deeming Resources from Ineligible Parent(s) to a Medicaid Child

If two parents are living in the household with the Medicaid child, deem the parents' resources as follows:

- Subtract the Couple resource limit appropriate for the COA from the combined countable resources of both parents.
- Deem the amount in excess of the Couple resource limit to the eligible child(ren).

If the Medicaid child enters LA-D, deem the parent(s)' resources for the month of admission to LA-D. Consider only the child's resources beginning the month following the month of admission to LA-D.

Parent to Child Deeming of Income

Complete parent to child deeming of income on Form 171 if the A/R is a Medicaid child living in the household with his/her parent(s). Refer to Section 2508, Parent to Child Deeming.

EXCEPTION: DO NOT deem the income of a parent(s) for any month eligibility is determined for a Medicaid child in LA-D under a COA that uses the Medicaid CAP as the income limit. Refer to Section 2510, Medicaid CAP Budgeting.

2503 - COUPLES

POLICY STATEMENT

The income and resources of a Medicaid Couple are considered jointly in determining ABD Medicaid eligibility as long as they live together in LA-A or B.

BASIC CONSIDERATIONS

If the Couple resource limit is used to determine resource eligibility, the countable resources of both spouses are combined and applied to the appropriate Couple resource limit.

If the Spousal Impoverishment resource limit is used to determine resource eligibility, the countable resources of both spouses are combined and applied to the Spousal Impoverishment resource limit. Refer to Determining Resources when an A/R with a Community Spouse Enters LA-D in the PROCEDURES portion of Section 2502, Deeming.

If a Couple budget is completed to determine income eligibility, the combined countable income of both spouses and the appropriate Couple income limit are used to complete the budget. Refer to Section 2509, Couple Budgeting.

If a spouse to spouse deeming budget is used to determine income eligibility, both the appropriate Individual and Couple income limits are used to complete the budget. Refer to Section 2507, Spouse to Spouse Deeming.

If a Medicaid CAP budget is used to determine income eligibility, the Medicaid CAP is the income limit used to complete the budget. Refer to Section 2510, Medicaid CAP Budgeting.

PROCEDURES

Follow the procedures below to determine financial eligibility for a Medicaid Couple living together in LA-A or B and applying under the same class of assistance (COA):

Determining Financial Eligibility for a Medicaid Couple Living Together in LA-A or B

Combine the countable resources of both spouses and apply them to the appropriate Couple resource limit to determine resource eligibility.

Complete a Couple budget using the combined gross countable unearned and earned income of both spouses to determine income eligibility. Use the appropriate Couple income limit.

PROCEDURES (cont.)

Deeming Financial Eligibility when Both Spouses Enter LA-D

Follow the procedures below to determine financial eligibility when both spouses enter LA-D in the same month.

Resource Eligibility

Combine the countable resources of both spouses and apply them to the Couple resource limit to determine resource eligibility for the month of admission to LA-D.

Treat each spouse as an Individual in determining resource eligibility beginning the month following the month of admission to LA-D. Apply each Individual's resources to the Individual resource limit.

Income Eligibility

If both spouses have eligibility determined under a COA that uses the Medicaid CAP as the income limit, treat each spouse as an Individual when determining income eligibility beginning with the month of admission to LA-D. Complete a Medicaid CAP budget. Refer to Section 2510, Medicaid CAP Budgeting.

If both spouses have eligibility determined as ABD Medically Needy, complete a Couple budget for the month of admission to LA-D. Complete an Individual budget on each spouse beginning the month after the month of admission to LA-D. Refer to Section 2506, Medicaid Individual Budgeting.

PROCEDURES (cont.)

Use the following chart to determine treatment of income and resources when both spouses are Medicaid and/or QMB/SLMB/QI-1/QI-2 eligible and have eligibility determined under different classes of assistance. Consider Spouse A to be residing at home in LA-A or B:

CHART 2503.1 - FINANCIAL RESPONSIBILITY FOR MEDICAID COUPLES		
	SPOUSE A	**SPOUSE B**
CLASS OF ASSISTANCE:	**AMN**	**SSI**
Resource:	Use the AMN Couple resource limit.	Use the SSI Couple resource limit
Income:	Complete a Couple budget.	Complete a Spouse to Spouse Deeming budget.
CLASS OF ASSISTANCE:	**AMN**	**CCSP, Hospice at home or Hospital (when LOS is met)**
Resource:	Use the AMN Couple resource limit any month in which Spouse B is in the home at least one day.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the hospital, hospice or CCSP. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	Complete a Couple budget if the couple are together at home on the first day of the month.	Complete a Medicaid CAP budget.
CLASS OF ASSISTANCE:	**AMN**	**Nursing Home**
Resource:	Use the AMN Couple resource limit through the month of admission of Spouse B to the nursing home (NH). Use the AMN Individual resource limit beginning the month after the month of admission.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the nursing home (NH). Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	Complete a Couple budget though the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission. **NOTE**: Include any income diverted from Spouse B in the Individual budget.	Complete a Medicaid CAP budget.

Chart 2503.1 - Financial Responsibility for Medicaid Couples (cont.)		
	SPOUSE A	**SPOUSE B**
CLASS OF ASSISTANCE:	**AMN**	**AMN IN HOSPITAL**
Resource:	Use the AMN Couple resource limit. Also, refer to Special Considerations at the end of this section.	Use the AMN Couple resource limit. Also, refer to Special Considerations at the end of this section.
Income:	Complete a Couple budget Also refer to Special Considerations at the end of this section	Complete a Couple budget. Also refer to Special Considerations at the end of this section.
CLASS OF ASSISTANCE:	**AMN (QMB/SLMB eligible)**	**QMB/SLMB/QI-1/QI-2**
Resource:	Use the AMN Couple resource limit.	Use the QMB/SLMB/QI-1/QI-2 Couple Resource limit.
Income:	Complete a Spouse to Spouse Deeming budget.	Complete a Couple budget.
CLASS OF ASSISTANCE:	**AMN (not QMB/SLMB/QI-1/QI-2 eligible)**	**QMB/SLMB/QI-1/QI-2**
Resource:	Use the AMN Couple resource limit.	Use the QMB/SLMB/QI-1/QI-2 Couple resource limit.
Income:	Complete a Couple budget.	Complete a Spouse to Spouse Deeming budget.
CLASS OF ASSISTANCE:	**Public Law**	**QMB/SLMB/QI-1/QI-2**
Resource:	Use the SSI Couple resource limit.	Use the QMB/SLMB/QI-1/QI-2 Couple resource limit.
Income:	Complete a Spouse to Spouse Deeming budget.	Complete a Spouse to Spouse Deeming budget. If Spouse A is ineligible for QMB/SLMB/QI-1/QI-2. OR Complete a QMB/SLMB/QI-1/QI-2 Couple budget, if Spouse A is QMB/SLMB/QI-1/QI-2 eligible.

Chart 2503.1 - Financial Responsibility for Medicaid Couples (cont.)		
	SPOUSE A	**SPOUSE B**
CLASS OF ASSISTANCE:	**Public Law**	**Nursing Home**
Resource:	Use the SSI Couple resource limit through the month of admission of Spouse B to the NH. Use the SSI Individual resource limit beginning the month after the month of admission.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the NH. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	Complete a Couple budget through the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission.	Complete a Medicaid CAP budget.
CLASS OF ASSISTANCE:	**Public Law**	**CCSP, Hospice at home or Hospital**
Resource:	Use the SSI Couple resource limit. Also refer to Special Considerations at the end of this section.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the hospital, hospice or CCSP. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	Complete a Couple budget. Also refer to Special Considerations at the end of this section.	Complete a Medicaid CAP budget.

Chart 2503.1 - Financial Responsibility for Medicaid Couples (cont.)		
	SPOUSE A	**SPOUSE B**
CLASS OF ASSISTANCE:	**QMB/SLMB/QI-1/QI-2**	**CCSP, Hospice at home or Hospital**
Resource:	Use the QMB/SLMB/QI-1/QI-2 Couple resource limit. Also refer to Special Considerations at the end of this section.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to LA-D. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	If Spouse B is a QMB/SLMB/QI-1/QI-2 eligible, complete a Couple budget. If Spouse B is not QMB/SLMB/QI-1/QI-2 eligible, complete a Spouse to Spouse Deeming budget. Refer to Special Considerations at the end of this section.	Complete a Medicaid CAP budget.
CLASS OF ASSISTANCE:	**QMB/SLMB/QI-1/QI-2**	**Nursing Home**
Resource:	Use the QMB/SLMB/QI-1/QI-2 Couple resource limit through the month of admission of Spouse B to the NH. Use the QMB/SLMB/QI-1/QI-2 Individual resource limit beginning the month after the month of admission.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the NH. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	If Spouse B is a QMB/SLMB/QI-1/QI-2 eligible, complete a Couple budget through the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission. If Spouse B is not QMB/SLMB/QI-1/QI-2 eligible, complete a Spouse to Spouse Deeming budget through the month of admission. Complete an Individual budget beginning the month after the month of admission.	Complete a Medicaid CAP budget.

Chart 2503.1 - Financial Responsibility for Medicaid Couples (cont.)		
	SPOUSE A	**SPOUSE B**
CLASS OF ASSISTANCE:	**QMB/SLMB/QI-1/QI-2**	**AMN in Nursing Home**
Resource:	Use the QMB/SLMB/QI-1/QI-2 Couple resource limit through the month of admission of Spouse B to the NH. Use the QMB/SLMB/QI-1/QI-2 Individual resource limit beginning the month after the month of admission.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the NH. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	If Spouse B is QMB/SLMB/QI-1/QI-2 eligible, complete a Couple budget through the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission. If Spouse B is not QMB/SLMB/QI-1/QI-2 eligible, complete a Spouse to Spouse Deeming budget through the month of admission. Complete an Individual budget beginning the month after the month of admission.	Complete an Individual budget beginning the month of admission.
CLASS OF ASSISTANCE:	**QMB/SLMB/QI-1/QI-2**	AMN in Hospital
Resource:	Use the QMB/SLMB/QI-1/QI-2 Couple resource limit. Also, refer to Special Considerations at the end of this section.	Use the AMN Couple resource limit. Also, refer to Special Considerations at the end of this section.
Income:	If Spouse B is QMB/SLMB/QI-1/QI-2 eligible, complete a Couple budget. If spouse B is not QMB/SLMB/QI-1/QI-2 eligible, complete a Spouse to Spouse Deeming budget. Refer to Special Considerations at the end of this section.	Complete a Spouse to Spouse Deeming budget. Also, refer to Special Considerations at the end of this Section.

Chart 2503.1 - Financial Responsibility for Medicaid Couples (cont.)		
	SPOUSE A	**SPOUSE B**
CLASS OF ASSISTANCE:	**QMB/SLMB/QI-1/QI-2 (not SSI eligible)**	**SSI**
Resource:	Use the QMB/SLMB/QI-1/QI-2 Couple resource limit.	Use the SSI Couple resource limit.
Income:	If Spouse B is QMB/SLMB/QI-1/QI-2 eligible, complete a Couple budget. If Spouse B is not QMB/SLMB/QI-1/QI-2 eligible. Complete an Individual budget.	Complete a Spouse to Spouse Deeming budget.

SPECIAL CONSIDERATIONS

Hospitalization Treated as a Temporary Absence

Hospitalization is generally considered to be a temporary absence from the home.

- The hospitalized spouse is considered to be living in the home with his/her Medicaid spouse during the hospital confinement.
- The hospitalized spouse's income and resources are considered when determining the Medicaid eligibility of the Medicaid spouse remaining at home.
- Refer to Chart 2503.1, Financial Responsibility for Medicaid Couples.

Hospitalization Treated as Full Separation of Spouses

Do not consider the income and resources of the hospitalized spouse beyond the month of hospital admission when determining the Medicaid eligibility of his/her spouse at home if the hospitalized spouse meets the length of stay (LOS) basic eligibility requirement.

The LOS requirement may be met by the hospitalization, or the hospitalization and a subsequent stay in another LA-D situation. Use this rule on separation even if the hospitalized spouse's eligibility is determined under ABD Medically Needy.

If the hospitalized/LA-D spouse returns home to live with his/her spouse after meeting the LOS requirement, resume considering the income and resources of the spouses jointly for purposes of determining Medicaid eligibility effective with the month following the month the hospitalized/LA-D spouse returns home.

NOTE: The income of the spouse is not considered if eligibility is determined under a COA that uses the Medicaid CAP as the income limit. Refer to Section 2510, Medicaid CAP Budgeting.

NOTE: Use the Spousal Impoverishment resource limit in determining the hospitalized/LA-D spouse's eligibility if the conditions for a full separation of spouses are met as outlined above.

2504 – DETERMINING COUNTABLE INCOME

POLICY STATEMENT

Countable income for determining ABD Medicaid eligibility may include more or less income than is actually received. Countable income is determined for each month separately based on income received each month.

BASIC CONSIDERATIONS

The following are examples of situations where more or less income than the A/R actually receives is included in the eligibility and patient liability/cost share budgets:

- Expenses of obtaining income (less)
- Expenses of converting payments in foreign currency to U.S. dollars (less)
- Garnishment (more)
- Gross earnings, before any deductions (more)
- Infrequent or irregular income (less).

NOTE: A portion of the A/R's income may be excluded based on the type of income received, such as child support. Refer to Chart 2499.1, Treatment of Income in Medicaid.

Expenses of Obtaining Income

An expense that is essential to obtain a particular payment(s) is deducted from the gross income.

A fee to acquire documentation to establish that an individual has a right to certain income (e.g., a fee for a birth certificate, legal fee, or medical examination) is an essential expense.

A guardianship fee is an essential expense if the presence of a guardian is a requirement for receiving the income. In cases where SSA requires that payments be made to a representative payee, the appointment of a legal guardian is unnecessary, and guardianship fees are not allowable.

PROCEDURES

Deduct that part of a payment that is an essential expense incurred in obtaining the payment.

- Subtract legal, medical and other expenses connected with an accident from the payment for damages received in the accident.
- Subtract legal fees connected with that claim if an individual receives a retroactive payment from a benefit program other than SSI.

Deduct expenses from the first and any subsequent payments of the same type of income until all expenses are eliminated.

PROCEDURES

Expenses of Obtaining Income (cont.)

- Deduct those verified expenses which the recipient has previously paid (e.g., a partial payment to an attorney made from the individual's savings account) as long as the expenses are essential.

- Use bills, receipts, contact with the provider, etc., to verify all essential expenses.

- Consider the remainder as unearned income subject to the general rules pertaining to income and income exclusions.

An individual may receive income tendered to him/her in a monetary unit other than U.S. dollars.

Consider the U.S. dollar value of a payment made in foreign currency, less expenses, as income.

Expenses in Converting Payments in Foreign Currency to U.S. Dollars

Count foreign currency payments received. If the individual alleges and can establish that the payment was received too late in the month for conversion, count the payment as income for the following month.

Use a check or documents in the individual's possession to verify receipt of a foreign payment and the amount in foreign currency. If the payment is made directly to a bank, the bank may provide a statement of the amount received.

If the evidence is not readily available, or if translation of the documents would require a delay beyond the receipt of the next payment, complete the following procedures:

- Accept the individual's signed statement.
- Ask the individual to present his next check before cashing it.

Verify the exchange rate for conversion to the foreign currency into U.S. dollars using one of the following:

- a receipt for the individual's last exchange
- a telephone call to a local bank or currency exchange.

Presume that an established exchange rate remains constant until the next review. If, at the next review, the exchange rate has changed, presume the change occurred in the month of verification.

EXCEPTION: If the individual reports that the exchange rate has changed, verify the change and adjust the income charged to reflect the new rate.

PROCEDURES (cont.)

Garnishment

A garnishment is withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation.

Include a garnishment from earned or unearned income as income for Medicaid eligibility and patient liability budgeting purposes.

Include garnishments based on any of the following as income:

- voluntary agreement
- repayment of a debt
- satisfying a legal obligation.

NOTE: This policy does not apply to amounts withheld to pay the expense of obtaining the income, since such amounts are not income.

Gross Income Withholding

Do not allow the following items as deductions from income for ABD Medicaid eligibility budgeting purposes:

- alimony payments, court ordered or voluntary
- child support payments, court ordered or voluntary
- federal, state, or local income taxes
- garnishments
- guardianship fees if the presence of a guardian is not a requirement for receiving the income
- health or life insurance premiums
- inheritance taxes
- loan payments
- penalty deductions for failure to report changes
- service fees charged on interest-bearing checking accounts
- SMI (Medicare Part B) premiums
- union dues.

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

NOTE: Refer to Chapter 2552, Patient Liability Budgeting, for a list of deductions allowed in the patient liability/cost share budget.

PROCEDURES (cont.)

Estimated Income

Estimate current and future monthly income.

If the amount is the same each payday, multiply the amount by the number of paydays in the month to obtain the monthly amount.

When income fluctuates within a month, use representative income to represent the amount of income for each period of receipt.

- Determine representative income by using an average of the amounts from the last 4 periods or by using the amount indicated by the A/R as most representative.
- Multiply the representative income by the number of periods of receipt in the month being budgeted to obtain the anticipated monthly income.

Income Expected Less Than Once a Month

Determine the specific month(s) the income is expected to be received and budget the amount for the appropriate month(s).

Infrequent or Irregular Income

Exclude income received either infrequently or irregularly, provided the total of such income does not exceed the following amounts:

- $10 per month of earned income

AND/OR

- $20 per month of unearned income.

In order for this exclusion to apply, income need only be one of the following:

- Infrequent – income received no more than once in a calendar quarter from a single source.
- Irregular – income that the A/R cannot reasonably expect to receive on a regular basis.

PROCEDURES (cont.)

Total Exceeds the Limit

Apply this exclusion to both earned and unearned income in the same month, provided the total of each does not exceed the limits above. It is possible to exclude as much as $30 a month under this provision.

Include all income received on an infrequent or irregular basis in the eligibility budget if the total of such income received in a particular month exceeds the limits stated above.

Limit as It Applies to Medicaid Couples or a Medicaid Individual with an Ineligible Spouse

Apply only one exclusion each month to income received infrequently or irregularly by a Medicaid individual, Medicaid couple, ineligible spouse, ineligible parent and ineligible child.

Determining Frequency of Receipt

Determine the frequency of the income by reviewing the receipts of the same type of income from a single source.

Interest Income of $20 or Less per Month

Refer to Interest in Chart 2499.1, Treatment of Income in Medicaid, for information on the exclusion of interest income of $20 per month or less.

2505 – INCOME DEDUCTIONS

POLICY STATEMENT

Income deductions are subtracted from income when budgeting to determine income eligibility for ABD Medicaid.

These deductions are not allowed in Medicaid CAP cases.

BASIC CONSIDERATIONS

Income deductions apply to all earned and unearned income except Income Based On Need (IBON). IBON includes, but is not limited to, the following types of income:

- TANF
- IV-E Foster Care/Adoption Assistance
- SSI
- VA Pension
- VA compensation only when received by a parent(s) due to his/her child's military related death
- Other needs based on payment from private organizations (e.g., Salvation Army, Catholic charities).

PROCEDURES

Unearned Income Deductions

Subtract a $20 general deduction from each month of unearned income.

Subtract only one $20 general deduction from the unearned income of each of the following:

- a Medicaid Individual
- a Medicaid Individual and his/her Ineligible Spouse
- a Medicaid Couple
- a Medicaid Child
- an Ineligible Parent(s).

Earned Income Deductions

Subtract earned income deductions for each month of earned income in the following order:

- Deduct up to $400 per month, but not more than $1,620 in a calendar year, of the earned income of a blind or disabled child who is a student.
- Subtract the remainder of the $20 general deduction from the combined earned income of the following A/Rs and/or deemors:
  - a Medicaid Individual
  - a Medicaid Couple or a Medicaid Individual with an Ineligible Spouse
  - a Medicaid Child
  - Ineligible Parents.

PROCEDURES (cont.)

Earned Income Deductions (cont.)

Deduct $65 of gross earned income. Subtract the deduction from the combined earned income of the following A/Rs and/or deemors:

- a Medicaid Individual
- a Medicaid Couple or a Medicaid Individual with an Ineligible Spouse
- a Medicaid Child
- Ineligible Parents.

- Deduct the earned income of disabled Individuals used to pay impairment-related work expenses.
- Deduct one-half of any remaining earned income.
- Deduct the earned income of blind Individuals used to meet work expenses. Deduct any earned income used to fulfill an approved Plan to Achieve Self Sufficiency (PASS).

Applying Earned Income Deductions

Use the following guidelines when applying the earned income deductions:

- Never reduce earned income below zero.
- Do not apply any unused portion of an earned income deduction to unearned income.
- Do not apply any unused portion of an earned income deduction in subsequent months.

PROCEDURES (cont.)

Student Child Earned Income Deduction

Deduct up to $400 per month, but not more than $1,620 in a calendar year, of the earned income of a blind or disabled child A/R who is a student regularly attending school.

Give the student earned income deduction to an Individual who meets all the following criteria:

- is a child under age 22
- is unmarried
- is not the head of the household
- is a student regularly attending (or expects to attend) school at least one month of the current calendar quarter.

Apply the deduction using the following guidelines:

- Apply the deduction consecutively to months in which the child has earned income until the deduction is exhausted or the Individual is no longer a student child.
- Apply the deduction only to a student child's own earned income.
- Do not count earnings received prior to the first month of Medicaid eligibility toward the $1,620 annual limit.

Develop the following factors and document them:

- whether the child was regularly attending school in at least one month of the current calendar quarter, or expects to attend school for at least one month in the next calendar quarter;
- the amount of the child's earned income, including payments from Neighborhood Youth Corps, Work-Study, and similar programs;
- the amount of the student earned income deduction for each month it is allowed in the eligibility budget.

PROCEDURES (cont.)

Deduction of Blind Work Expenses (BWE)

Deduct the amount of earned income of a blind person which is used to meet any expenses reasonably attributed to earning the income if the blind person meets one of the following criteria:

- is under age 65
- is age 65 or older and received SSI payments or payments under a former state plan for aid to the blind for the month before he/she attained age 65.

Deduct the BWE from earned income only. Do not deduct BWE in excess of the earned income from unearned income.

Deduct BWE from the earned income which remains after applying the $20 general income deduction and all other earned income deductions except income used to fulfill an approved Plan to Achieve Self Support (PASS).

Impairment Related Work Expenses (IRWE) Deductions

Contact the Medicaid Unit at the State Office for instructions on allowing this deduction for a disabled Individual who is currently employed.

2506 – MEDICAID INDIVIDUAL BUDGETING

POLICY STATEMENT

Individual budgeting is completed when an individual residing in LA-A or B applies for or receives ABD Medicaid as a Medicaid Individual with no spouse.

BASIC CONSIDERATIONS

An individual budget is completed for a Medicaid Individual residing in LA-A or B without a spouse whose eligibility is determined under the following classes of assistance (COAs):

- SSI (3 months prior or intervening months)
- Public Law Classes, including Disabled Widow(er) and Disabled Adult Child (DAC)
- ABD Medically Needy (AMN)
- QMB
- QDWI
- SLMB
- QI-1
- QI-2

PROCEDURES

Enter the appropriate information in the computer system to allow the system to budget correctly.

OR

Follow the procedures below to manually complete an Individual budget on Form 172:

Step 1 Complete Section A of Form 172.

- Include the income of the Medicaid individual in Section A.
- Use the Individual income limit for the COA under which the Medicaid individual is applying.

Step 2 If there is a deficit on Line 13 of Section A, the Medicaid individual is eligible under this COA based on income.

Step 3 If there is a surplus or zero on Line 13 of Section A, the Medicaid individual is ineligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

EXCEPTION: If the individual is applying for QMB and there is a zero on Line 13, the individual is eligible for QMB based on income.

EXCEPTION: If the individual is being budgeted under AMN and there is a surplus on Line 13, use the amount from Line 13 as the AMN spenddown.

2507 – SPOUSE TO SPOUSE DEEMING

POLICY STATEMENT

Spouse to spouse deeming is completed when an individual residing in LA-A or B with his/her spouse applies for or receives ABD Medicaid as a Medicaid individual with an ineligible spouse.

BASIC CONSIDERATIONS

A spouse to spouse deeming budget is completed for a Medicaid individual who is residing in LA-A or B with his/her ineligible spouse and whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs):

- SSI (3 months prior or intervening months)
- Public Law Classes, including Disabled Widow(er) and Disabled Adult Child (DAC)
- ABD Medically Needy (AMN)
- QMB
- QDWI
- SLMB
- QI-1
- QI-2

PROCEDURES

Refer to Section 2502, Deeming, for additional information on when to complete Spouse to Spouse Deeming.

Enter the appropriate information in the computer system to allow the system to budget correctly.

OR

Follow the steps below to manually complete a Spouse to Spouse Deeming budget on Form 172:

Step 1 Complete Section A of Form 172.

- Include the income of the Medicaid individual in Section A.
- Use the Individual income limit for the COA under which the Medicaid individual is applying.

If there is a deficit on Line 13 of Section A, proceed to Step 2.

If there is a surplus or zero on Line 13 of Section A, discontinue budgeting. The individual is ineligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

EXCEPTION: If the individual is applying for QMB and there is a zero on Line 13, proceed to Step 2.

EXCEPTION: If the individual is being budgeted under AMN and there is a surplus on Line 13, proceed to Step 2.

PROCEDURES (cont.)

Step 2 Complete Section B of Form 172.

- Include only the income of the ineligible spouse in Section B. **DO NOT** include Income Based On Need (IBON) or any income used to determine IBON.
- On Line 2, subtract the allocation to the ineligible child(ren)* from the ineligible spouse's **UNEARNED** income first.
- If any portion of the allowable allocation amount remains after subtracting it from the unearned income, subtract the remainder from the ineligible spouse's **EARNED** income.
- Proceed to Step 3.

EXCEPTION: If the individual is being budgeted as AMN and the combined total of the amounts on Line 3 and Line 6 of Section B is less than or equal to one-half of the MNIL for an individual, discontinue budgeting and use the amount from Line 13 of Section A (first potential spenddown) as the AMN spenddown..

***NOTE:** Allocate the amount remaining after subtracting the ineligible child's gross income from the living allowance for an ineligible child. Refer to Appendix A for correct living allowance for the COA.

Step 3 Complete Section C of Form 172.

- Include the income of the Medicaid individual and the ineligible spouse in Section C.
- Allow only one $20 general deduction and one $65 earned income deduction when completing Section C.

If there is a deficit on Line 13 of Section C, the Medicaid individual is eligible under this COA based on income.

If there is a surplus or zero on Line 13 of Section C, the Medicaid individual is ineligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

EXCEPTION: If the individual is applying for QMB and there is a zero on Line 13 of Section C, the individual is eligible for QMB based on income.

EXCEPTION: If the individual is being budgeted under AMN and there is a surplus on Line 13 of Section C, use the amount from Line 13 of Section A (first potential spenddown) or the amount from Line 13 of Section C (second potential spenddown) as the AMN spenddown, whichever is greater.

2508 – PARENT TO CHILD DEEMING

POLICY STATEMENT	Parent to child deeming is completed when a child residing with his/her parent(s) applies for or receives ABD Medicaid.
BASIC CONSIDERATIONS	A parent to child deeming budget is completed for a Medicaid child who is residing with his/her ineligible parent(s) and whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs): • SSI (3 months prior or intervening months) • Deeming Waiver (SSI trial budget) • ABD Medically Needy (AMN)
PROCEDURES	Refer to Section 2508 for additional information on when to complete Parent to Child Deeming. Enter the appropriate information on the computer system to allow the system to budget correctly. **OR** Follow the steps below to complete a Parent to Child Deeming budget on Form 171:
Step 1	Complete Section A of Form 171. • Include the countable income of the ineligible parent (s) in Section A. **DO NOT** include Income Based On Need (IBON) or any income used to determine IBON. • On Line 2, subtract the allocation to the ineligible child(ren)* from the ineligible parent(s)' UNEARNED income first. • If any portion of the allowable allocation amount remains after subtracting it from the unearned income, subtract the remainder from the ineligible parent(s)' EARNED income. **NOTE:** Allocate the amount remaining after subtracting the ineligible child's gross income from the living allowance for an ineligible child. The living allowance for an ineligible child is the difference in the Individual and Couple FBRs for LA-A.

PROCEDURES (cont.)

Step 2 If there is a deficit or zero on Lines 3 and 6 of Section A, proceed to Step 3.

If there is a surplus on Line 3 and/or Line 6 of Section A (unearned and/or earned income remains), complete Section B of Form 171. Use the unearned and earned income remaining on Lines 3 and 6 of Section A to complete Section B.

Step 3 Complete Section C of Form 171.

- Include all countable income of the Medicaid child.
- Include any income remaining on Line 13 of Section B as unearned income deemed from the ineligible parent(s).

If there is a deficit on Line 13 of Section C, the Medicaid child is eligible under this COA based on income.

If there is a surplus or zero on Line 13 of Section C, the Medicaid child is ineligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

EXCEPTION: If the child's eligibility is determined under the Deeming Waiver COA, complete a Medicaid CAP budget as the final step in determining income eligibility.

EXCEPTION: If the child is budgeted as AMN and there is a surplus on Line 13 of Section C, use the amount from Line 13 of Section C as the AMN spenddown.

2509 – COUPLE BUDGETING

POLICY STATEMENT

Couple budgeting is completed when an individual and his/her spouse residing in LA-A or B both apply for or receive ABD Medicaid as a Medicaid couple.

BASIC CONSIDERATIONS

A couple budget is completed for a Medicaid couple residing in LA-A or B whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs):

- SSI (3 months prior or intervening months)
- Public Law Classes, including Disabled Widow(er) and Disabled Adult Child (DAC)
- ABD Medically Needy (AMN)
- QMB
- QDWI
- SLMB
- QI-1
- QI-2

PROCEDURES

Refer to Section 2503, Couples, for additional information on when to complete a couple budget.

Enter the appropriate information in the computer system to allow the system to budget correctly.

OR

Follow the procedures below to complete a manual couple budget on Form 172.

Step 1 Complete Section C of Form 172.

- Include the income of both spouses of the Medicaid couple in Section C.
- Allow only one $20 general deduction and one $65 earned income deduction when completing Section C.

Step 2 If there is a deficit on Line 13 of Section C, the Medicaid couple is eligible under this COA based on income.

PROCEDURES (cont.)

Step 3 If there is a surplus or zero on Line 13 of Section C, the Medicaid couple is ineligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

EXCEPTION: If the couple is applying for QMB and there is a zero on Line 13, the individual is eligible for QMB based on income.

EXCEPTION: If the couple is being budgeted under AMN and there is a surplus on Line 13, use the amount from Line 13 as the AMN spenddown.

NOTE: If the couple is ineligible for all COAs using Couple budgeting, complete a Spouse to Spouse Deeming budget on each spouse to determine whether one or the other spouse is eligible based on income as a Medicaid individual with an ineligible spouse.

2510 – MEDICAID CAP BUDGETING

POLICY STATEMENT

Medicaid CAP budgeting is completed when an individual resides in LA-D and applies for ABD Medicaid.

EXCEPTION: If the A/R income exceeds the Medicaid CAP, ABD Medicaid eligibility is determined under ABD Medically Needy (AMN) using the ABD Medically Needy Income Level (AMNIL).

BASIC CONSIDERATIONS

A Medicaid CAP budget is completed for an A/R who is residing in LA-D with or without his/her spouse and whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs):

- Community Care Services Program (CCSP)
- Deeming Waiver (Katie Beckett)
- Hospice Care
- Hospital
- Independent Care Waiver Program (ICWP)
- Nursing Home
- MRWP/CHSS

PROCEDURES

Follow the steps below to complete a Medicaid CAP budget. Document all calculations in the appropriate income sections of SUCCESS or interview document:

Step 1 Calculate the GROSS countable monthly income of the Medicaid A/R residing in LA-D.

NOTE: Do not include the income of the A/R's spouse, even if the A/R lives at home in LA-D with his/her spouse.

Step 2 Compare the GROSS countable monthly income to the Individual Medicaid CAP.

NOTE: Do not allow the income deductions discussed in Section 2505, Income Deductions.

If the A/R's gross income is less than the Individual Medicaid CAP, the A/R is eligible under this COA based on income.

If the A/R's gross income is greater than or equal to the Individual Medicaid CAP, the A/R is ineligible under this COA based on income. Budget the A/R as Medically Needy.

SPECIAL CONSIDERATIONS

Couple Medicaid CAP

Use the Couple Medicaid CAP only when the following conditions are met:

- Both spouses of a Medicaid couple reside together in LA-D at home or in the same nursing home or hospital.

AND

- Using the Individual Medicaid CAP results in Medicaid ineligibility for one of the spouses.

If the Couple Medicaid CAP is used, complete the Medicaid CAP budget as follows:

- Combine the gross countable monthly income of the Medicaid couple.
- Compare the combined income to the Couple Medicaid CAP.

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2551 - PATIENT LIABILITY/COST SHARE OVERVIEW

POLICY STATEMENT	A patient liability/cost share is determined for certain Medicaid recipients in long-term care (LA-D).
BASIC CONSIDERATIONS	A patient liability/cost share amount is determined for the following ABD Medicaid recipients: • a Medicaid recipient in a nursing home whose eligibility is determined under the nursing home class of assistance (COA) • a Medicaid recipient who is receiving Community Care Services Program (CCSP) services at home • a Medicaid recipient who is receiving Community Habilitation Support Services (CHSS) or Mental Retardation Waiver Program (MRWP) Services at home • a Medicaid recipient who is receiving Independent Care Waiver Program (ICWP) services at home • an ABD Medically Needy recipient who resides in a nursing home. A patient liability/cost share amount is determined at the following times: • at application • at each review • when a change in income occurs • when a change in incurred medical expenses (IME) occurs • at the beginning of each new averaging period. **NOTE:** The monthly patient liability for a nursing home or nursing home AMN A/R will never exceed the monthly Medicaid billing rate for the nursing home in which they reside. In this situation, the caseworker must manually enter in the system a patient liability amount equal to the Medicaid billing rate after appropriate patient liability deductions are allowed. A CCSP A/R who enters a nursing home will have a zero patient liability for the month of admission to the nursing home. The A/R is responsible for paying their regular CCSP cost share for the month of admission to the nursing home. A nursing home A/R who enters CCSP will have a zero cost share for the month of admission to CCSP. The nursing home patient liability should be recalculated for the month of discharge using the FBR as the PNA.

BASIC CONSIDERATIONS (cont.)	When an A/R transfers directly from an out of state nursing home to a nursing home in Georgia, calculate the patient liability for the month of admission using the actual payment made to the out of state nursing home as an IME.
PROCEDURES	Follow the steps below to complete the patient liability/cost share determination process:
Step 1	Determine the average income and IME to use in the patient liability budget(s). Refer to Section 2557, Averaging Income and IME, and Section 2558, Significant Change in Income or IME.
Step 2	Complete a patient liability budget(s). Refer to Section 2559, Patient Liability/Cost Share Budgeting, for information on completion of the patient liability budget.
SPECIAL CONSIDERATIONS	
Effective Month of Change in Patient Liability	If the A/R or PR reports a change that causes a decrease in patient liability, make the change in patient liability effective no earlier than the month the change is reported. Include the change in the reconciliation process if income and IME are being averaged. Refer to Section 2557, Averaging Income and Incurred Medical Expenses. If a decrease in patient liability is not issued in a timely manner, the decrease may be handled by making the appropriate system changes to correct the patient liability amount(s) for the month of change and ongoing. Refer to Section 2257, Averaging Income and Incurred Medical Expenses and Section 2558, Significant Change in Income or IME, for instructions on how to handle a reported change that causes an increase in patient liability.

2552 – PATIENT LIABILITY/COST SHARE DEDUCTIONS

POLICY STATEMENT

The Medicaid recipient who is required to contribute toward the cost of care is allowed specific deductions in the patient liability/cost share budget.

BASIC CONSIDERATIONS

The patient liability/cost share is determined by using the recipient's gross income and allowing the following deductions:

- Mandatory Income Deductions
  - FICA
  - Federal Withholding Tax
  - State Withholding Tax
  - Mandatory Insurance
  - $40 State Work Therapy Program
- Medicare Premium
- Protection of Income
- Personal Needs Allowance
- Diversion of income to the following individuals:
  - Community Spouse
  - Dependent Family Member
  - Non-legal spouse
  - Couples under CCSP
- Incurred Medical Expenses (IME)

Mandatory Deductions

Mandatory deductions that are withheld from earned or unearned income are deducted from the recipient's gross income. However, if the recipient receives a tax refund from federal or state withholding tax, this will be considered as income the month the tax refund check is received.

Medicare Premium Deduction

The Medicare premium is deducted in the patient liability budgets for the first month of Nursing Home, CCSP, ICWP or MRWP Medicaid eligibility through the month following the month of Medicaid approval.

NOTE: The Medicare premium should already be paid by Medicaid for an individual who is receiving Medicaid, QMB or SLMB when s/he enters a nursing home, CCSP, ICWP or MRWP. The Medicare premium is not allowed as a deduction for these recipients.

Personal Needs Allowance (PNA)

The personal needs allowance (PNA) is the amount the recipient is allowed to retain to pay for incidental personal expenses.

PROCEDURES

Mandatory Deductions

Deduct mandatory deductions from the recipient's gross earned and unearned income if any are withheld by the employer or agency issuing the income.

Medicare Premium

If an A/R receives Part B Medicare, deduct the Medicare Part B premium as follows:

- Deduct in the patient liability budgets for the first month of nursing home or CCSP Medicaid eligibility through the month following the month of Medicaid approval.
- Complete a new budget to remove the Medicare premium deduction effective the second month following the month of approval.

If an ABD Medically Needy (AMN) Nursing Home recipient is consistently eligible for only part of the month, allow the Medicare premium deduction for each month the A/R meets the spenddown.

If an AMN Nursing Home recipient is consistently eligible for every day of the month, allow the Medicare premium deduction only through the month following the month of approval of the application.

If an AMN Nursing Home recipient who has been eligible for only part of the month has a change in circumstances that makes him/her eligible for every day of the month on a consistent basis, continue to allow the Medicare premium deduction only through the second consecutive month in which the AMN recipient is Medicaid eligible for every day of the month.

Protection of Income

Refer to Section 2553, Protection of Income, for procedures on allowing the protection of income deduction.

Personal Needs Allowance (PNA)

Deduct the PNA after allowing the deduction for protected income. Refer to Appendix A1 for the current amount of appropriate PNA to use in the patient liability budget.

Diversion of Income

Refer to Section 2554, Diversion of Income, for procedures on allowing the diversion of income deduction.

Incurred Medical Expenses

Refer to Section 2555, Incurred Medical Expenses, for procedures on allowing the deduction for IMEs.

2553 – PROTECTION OF INCOME

POLICY STATEMENT

All or part of the recipient's income is protected for the month of admission to or discharge from a nursing home (NH), CCSP or MRWP/CHSS.

BASIC CONSIDERATIONS

Income is protected for the month in which any of the following situations occurs:

- The recipient enters a NH, CCSP, ICWP or MRWP/CHSS from LA-A or B.
- The recipient leaves a NH, CCSP, ICWP or MRWP/CHSS and enters LA-A or B.
- The recipient has CCSP/MRWP/CHSS waivered services and case management terminated.
- The recipient is admitted to and leaves a NH, CCSP or MRWP/CHSS in the same month.
- The recipient is admitted to a NH, CCSP or MRWP/CHSS and dies in the same month.
- The recipient enters a NH, CCSP, ICWP or MRWP/CHSS in the same month in which s/he was admitted to a hospital or other LA-D from LA-A or B.

  NOTE: In the above situation, use the date of admission to the first LA-D as the admission date for determining the amount of protected income. For CCSP/ICWP/MRWP/CHSS cases, use the date case management begins.

Income Not Protected

Income is not protected for the month in which any of the following situations occurs:

- The recipient is admitted directly from another NH/CCSP/MRWP/ CHSS and has been continuously residing in a NH/CCSP/ MRWP/CHSS since prior to the first day of the month.
- The recipient dies in the NH/CCSP or MRWP/CHSS in a month other than the month of admission.
- The recipient is admitted to a NH/CCSP or MRWP/CHSS directly from a hospital or other LA-D in a month subsequent to the month of admission to the hospital/other LA-D from LA-A or B.
- The A/R is discharged from one LA-D to another LA-D situation.

NOTE: Third party vendor payment supplements and VA Aid and Attendance are not protected. Refer to Section 2556, VA Aid and Attendance.

PROCEDURES	Allow the protected income deduction when calculating the Patient Liability/Cost Share.

Use the following chart to determine the amount of the recipient's income to protect based on when the recipient entered and/or left LA-D:

CHART 2553.1 – PROTECTION OF INCOME

IF the recipient	THEN Protect
enters the 1st through the 10th day of the month	one half income
enters the 11th through 31st day of the month	ALL income
enters/leaves (leaves/enters) or dies in the same month **AND** the total stay is 10 days or less	ALL income
enters/leaves (leaves/enters) or dies in the same month **AND** the total stay is 11 days or more	one half income
leaves the 1st through 10th day of the month	ALL income
leaves the 11th through 31st day of the month	one half income
dies in a nursing home or CCSP in any month subsequent to the month of admission	NO income

NOTE: If an A/R enters and leaves a facility/facilities more than once during the same month, or if the A/R dies during the month of admission, the total number of days spent in the facility/facilities for the entire month is considered in determining protected income. Refer to the above chart.

- Count the day of admission towards the total stay.
- Do not count the day of discharge or death towards the total stay.

2554 – DIVERSION OF INCOME

POLICY STATEMENT

The income of a recipient in a nursing home, CCSP. MRWP/CHSS or ICWP may be diverted to a spouse and/or children at home to meet their needs.

BASIC CONSIDERATIONS

Diversion of income is allowed when a recipient with a spouse and/or dependents resides in a nursing home or CCSP.

The amount of income diverted is determined by subtracting the spouse/dependents(s) income from the appropriate need standard.

Income Diverted to a Community Spouse

The Community Spouse Maintenance Need Standard (CSMNS) is used to determine the amount of diverted income if the following conditions are met:

- The community spouse is available to receive the allowance.
- The recipient chooses to make the allowance available to the community spouse or to someone else for the benefit of the community spouse.

Income Diverted to a Dependent Family Member

The Dependent Family Member Maintenance Need Standard (DFMNS) is used to determine the amount diverted to a financially dependent family member who lives with the community spouse.

The family member must fall within the acceptable degree of relationship. The degree of the relationship can be either to the recipient or the community spouse and is restricted to the following:

- a minor child
- dependent child
- dependent parent
- dependent sibling, including half-sibling.

The family member must be claimed as a dependent on the most recent IRS tax return or have income less than the Individual FBR for LA-A in order to be considered financially dependent.

BASIC CONSIDERATIONS (cont.)

Income Diverted to a Dependent Family Member (cont.)

Income is diverted to a dependent family member regardless of the following factors:

- whether the recipient makes the income available to the dependent family member or to someone else on behalf of the dependent family member.
- whether income is diverted to the community spouse with whom the dependent family member is living.

Non-Legal Spouse

Income of the recipient may be diverted to a non-legal spouse/children at home to meet their needs.

- Use the Individual FBR for LA-A as the diversion standard for a non-legal spouse with no minor children at home.
- Use the TANF standard of need as the diversion standard for a non-legal spouse with minor children at home.

  NOTE: If the spouse and/or minor children are receiving TANF or SSI, the spouse may decide not to receive the diverted income to avoid possible ineligibility for SSI or TANF.

Couples Under CCSP

Diversion of income applies when both members of a Medicaid couple are in CCSP.

When one member of the couple (Spouse A) has income less than the individual FBR for LA-A, divert the income of his/her spouse (Spouse B) as follows:

- Subtract the income of Spouse A from the individual FBR for LA-A.
- Divert the amount from the above calculation (deficit) to Spouse A from Spouse B's income.

PROCEDURES

Obtain a Statement of Intent, Form 128, from the recipient or PR at the initial interview.

Obtain a statement from the recipient if the income being diverted is being provided to someone else for the care and upkeep of the community spouse/dependent family member.

Community Spouse

Determine the amount to be diverted using the adjusted gross income of the spouse and/or dependent family member, including In-Kind Support and Maintenance. The adjusted gross income is the individual's income after allowing mandatory deductions from earned and unearned income, such as federal and state income taxes, FICA and Medicare taxes. Refer to Section 2505, Income Deductions.

NOTE: Garnishments, child support and alimony payments are not considered to be mandatory deductions.

To calculate the income of the community spouse, use the same averaging procedures used to calculate the income of the A/R. Refer to Section 2557, Averaging Income and Incurred Medical Expenses.

Subtract the community spouse's average adjusted gross income from the CSMNS to obtain the amount of income to be diverted, known as the Community Spouse Maintenance Allowance (CSMA).

Dependent Family Member

Verify if the family member meets the following conditions for a dependent family member:

- falls within the degree of relationship
- meets the definition of financial dependency
- lives with the community spouse.

Verify the amount of gross income of the dependent family member. To calculate the income of the dependent family member, use the same averaging procedures used to calculate the income of the A/R. Refer to Section 2557, Averaging Income and Incurred Medical Expenses.

Subtract the dependent family member's average adjusted gross income from the DFMNS to obtain the amount of income to be diverted, known as the Dependent Family Member Allowance (DFMA).

PROCEDURES (cont.)

NOTE: You may divert to a dependent family member when there is NO community spouse in the home. Use the appropriate TANF standard of need for the number of dependents as the diversion standard.

Complete the appropriate fields so the system will calculate patient liability/cost share.

Use the following chart to determine the need standard to use when calculating the amount of the recipient's income to divert to a non-legal community spouse and child(ren).

Chart 2554.1 - Diversion to a Non-Legal Spouse and Child(ren)

IF	THEN
the spouse is potentially SSI eligible	divert up to the SSI FBR for the month of admission through the month following the month of case approval **AND** refer the spouse to SSA to apply for SSI. **NOTE:** Diversion of income can extend beyond 2 months only with approval from DMA. Secure approval from the following office: Eligibility Policy Officer Division of Medical Assistance P. O. Box 38445 Atlanta, Georgia 30334
the spouse and child(ren) are potentially eligible for TANF **OR** the child(ren) are potentially TANF eligible	divert up to the TANF standard of need for the month of admission through the month following the month of case approval **AND** refer this spouse to a TANF intake worker to file a TANF application. **NOTE:** Diversion of income can extend beyond 2 months only with approval from DMA.
the spouse is ineligible for SSI for reasons other than income	divert indefinitely up to the SSI FBR. **NOTE:** Potential eligibility for SSI must be explored at each review.
the spouse and child(ren) **OR** the child(ren) are ineligible for TANF	divert indefinitely up to the TANF standard of need. **NOTE:** Potential eligibility for TANF must be explored at each review.

2555 - INCURRED MEDICAL EXPENSES

POLICY STATEMENT

Medical expenses incurred by the recipient that are not subject to payment by Medicaid or other third parties can be deducted in the patient liability/cost share budget.

BASIC CONSIDERATIONS

Incurred medical expenses (IME) include the following:

- health and/or dental insurance premiums (100%)
- co-insurance and deductible payments not covered by Medicaid
- deductions for expenses not covered by Medicaid as listed on the DMA pricing document, such as the following:
  - dental services
  - medical supplies
  - orthopedic services
  - physician services
  - prescribed over the counter drugs
  - prescription drugs on the DMA pricing document
  - psychiatric or psychological services.

NOTE: This list is not all inclusive.

IMEs must be incurred by the recipient, but not necessarily paid by the recipient.

IMEs incurred in months for which no vendor payment is made are not deducted.

DMA Pricing Document

The DMA pricing document is a list of the medical services and supplies, which are allowable deductions.

The DMA pricing document will also identify certain items or services that are allowable deductions for CCSP recipients but not for nursing home recipients. These are primarily items and services which are included in the nursing home per diem reimbursement rate.

PROCEDURES

Health and/or Dental Insurance Premiums

Verify the following information on a health insurance premium from the source:

- that the policy is in force
- the amount of the premium
- the frequency of the premium

Health and/or Dental Insurance IME Deduction for Medicaid Couples

In situations where both spouses of a Medicaid couple reside in LA-D with a patient liability/cost share, allow the premium as an IME for the spouse who is financially responsible for payment of the premium. If both spouses are equally responsible or neither is designated as having primary financial responsibility for the premium payment, allow 50% of the premium as an IME for each spouse.

Other Deductions

Use Form 942 to determine the items or services requested as IMEs.

The following are requirements for Form 942:

- The signature of the provider must be an original signature; photocopied signatures are unacceptable.
- The question, "Was the above service or item prescribed or ordered in writing by a Physician?" must be answered YES.
- The question, "Is the recipient financially responsible for the item or service?" must be answered YES.

NOTE: Financially responsible means the item or service is not covered by Medicare or other health insurance and liability for the item or service has not been written off or forgiven by the provider.

- Date form received - must be received by the end of the averaging period in which the IME was incurred (the 10th of the reconciliation month) OR the 10th of the month following the month the IME was incurred if eligibility is determined under AMN.

PROCEDURES (cont.)

DMA Pricing Document

Compare Form 942 with the DMA Pricing Document to see if the item or service is listed.

Deduct the amount found in the pricing document or the amount charged by the provider, whichever is less.

IME Query

Send a query to DMA to determine if a medical expense can be deducted as an IME if it does not appear on the pricing document.

Denial of Medical Expense Hearing Request

Deny the IME deduction if the item or service is not approved by DMA.

NOTE: For certain expenses, such as drugs, the provider will have to specify quantity, size, strength of dosage, etc., in order for the expense to be correctly identified in the pricing document.

When a request for a deduction is denied, send Form 943 to the recipient prior to the last day of the month for which the deduction is requested.

Process a hearing for denial of IMEs using the same regular hearing procedures. Refer to Appendix D, Hearings.

Averaging

Use averaging procedures for the IME deduction. Refer to Section 2557, Averaging Income and Incurred Medical Expenses.

Averaging Period

Use a monthly average for the 3 months averaging period, when a one time IME is submitted. This could cause the liability to be reduced to zero for the entire averaging period. Refer to Section 2557, Averaging Income and Incurred Medical Expenses.

NOTE: There is no carryover of an excess IME to successive averaging periods.

IMEs in Medically Needy Patient Liability Budgets

For ABD Medically Needy Nursing Home cases where only projected expenses are used to meet the spenddown, deduct IMEs using the averaging procedures described in Section 2557, Averaging Income and Incurred Medical Expenses.

PROCEDURES

IMEs in Medically Needy Patient Liability Budgets (cont.)

For ABD Medically Needy Nursing Home cases where projected and actual expenses are used to meet the spenddown, deduct IMEs on a monthly basis **without** using averaging procedures.

- Include the full amount of the private pay nursing home billing rate per idem for the days of the month the A/R was **not** Medicaid eligible, as well as the full amount of any other medial expenses used to meet the spenddown if they were incurred in the month for which patient liability is calculated.

- Allow the amount indicated on the DMA Pricing Document as the IME deduction for any non-Medicaid covered medical expense incurred on a Medicaid eligible day.

- Refer to Section 2559, Patient Liability/Cost Share Budgeting.

  NOTE: Do **not** prorate the IME deduction based on the number of Medicaid eligible days.

Allowing the Deduction In the System

Calculate the IME deduction to be allowed in the patient liability/cost share budget and enter this amount in the incurred medical field on the INST screen. The system will allow the IME deduction as the last step in the budgeting process.

Client Notification

The system will send notification to the A/R and RP of the patient liability/cost share change for the month(s) for which the deduction is allowed. Customize this notification if more explanation is needed.

2556 - VA AID AND ATTENDANCE

POLICY STATEMENT	VA Aid and Attendance (A&A) is a payment made to veterans and certain dependents for medical and remedial care in their own home or a nursing home (NH). Housebound allowance is a payment made to veterans and certain dependents who do not require the aid and attendance of another person but who are permanently housebound due to disability.
BASIC CONSIDERATIONS	A&A is not considered in determining patient liability and cost share and is never considered as income for determining Medicaid eligibility. A&A is not considered for protection or diversion purposes in the patient liability budget. Unusual Medical Expense (UME) reimbursements are not considered in determining medical eligibility or patient liability/cost share. Housebound allowance is not considered in determining Medicaid eligibility or patient liability/cost share.
PROCEDURES	Verify the amount of monthly A&A by submitting Form 970, VA Communicator, to the local Veterans Services Office. Appropriately enter the verified amount of A&A or UME in the system. If the only VA income received is $90, that is the A/R's PNA. They do not receive an additional $30 PNA. If an A/R who does **not** receive A&A has a patient liability in excess of the monthly Medicaid billing rate for the NH in which s/he resides, enter a patient liability income in the system which will equal the Medicaid billing rate after all pertinent patient liability deductions are allowed.
Lump Sum VA A&A Payment/UME Reimbursement	Consider any remaining portion of the A&A lump sum as a resource beginning with the first month following the month of receipt. A&A lump sums or UME reimbursements are not reported to the DMA Third Party Liability Unit.

2557 - AVERAGING INCOME AND INCURRED MEDICAL EXPENSES

POLICY STATEMENT	Income and incurred medical expenses (IMEs) used in the patient liability budget are projected using an average of the income and IMEs from the previous three months.
BASIC CONSIDERATIONS	Averaging and reconciliation procedures are used in all patient liability and cost share budgets, **except** for AMN/NH that are not defacto eligible as the first day of the month. Averaging periods are three months, beginning with the month of admission to LA-D or the first month of Medicaid eligibility, whichever is later. **NOTE:** An averaging period may be shortened to avoid reconciling income at the end of a period that would cause hardship to an A/R. The expected average income and IMEs for the ongoing three months are projected as accurately as possible. The projected average is based on the following: • regular recurring income/IMEs received/incurred during the three previous months • regular recurring income/IMEs expected to be received/ incurred during the ongoing three month period • any irregular or non-recurring income/IMEs expected to be received during the ongoing three-month period (e.g. lump sums, quarterly interest, a large, one time IME). **NOTE:** The projection should not include income or IMEs received or incurred in the previous three months if it is not expected to be received or incurred in the ongoing three month period. Averaging periods can be flexible, depending on the receipt of unexpected income. A budget is completed every three months to reconcile the projected income with the actual income received.

PROCEDURES

Averaging	Follow the steps below to determine a monthly average income and IME.
Step 1	Verify the gross income received by the individual for each of the three months previous to the first month of the averaging period.
Step 2	Determine the total gross income for each month separately. Round each monthly total **down** to the nearest dollar.
Step 3	Add the monthly totals together and divide by three. Round **down** to the nearest dollar.
Step 4	Determine if the individual expects to receive any income in the averaging period which was not received in the previous three months (e.g., yearly farm rental income). Divide this total by three. Round **down** to the nearest dollar.
Step 5	Add the total from Step 3 to the total from Step 4. This is the projected monthly average income to be used in the patient liability budgets for the averaging period.
Step 6	Verify all allowable IMEs for each of the three months previous to the first month of the averaging period. Refer to Section 2555, Incurred Medical Expenses.
Step 7	Determine the total amount of IME for each month separately. Round each month's total **up** to the nearest dollar.
Step 8	Add the monthly totals together and divide by three. Round **up** to the nearest dollar.
Step 9	Determine if the A/R expects to incur any medical expense in the averaging period which was not incurred in the previous three months. Divide this total by three. Round **up** to the nearest dollar.
Step 10	Add the total from Step 8 to the total from Step 9. This is the projected monthly average IME to be used in the patient liability budgets for the averaging period.
Step 11	Complete patient liability budgets for the averaging period using the projected monthly averages for income and IME from step 10.

PROCEDURES (cont.)

Reconciliation

Reconcile the projected amounts of income and IME used for the averaging period with the actual income/IME received.

Reconciliation occurs in three instances:

- at the beginning of each new averaging period
- whenever a significant change occurs (refer to Section 2558, Significant Change in Income or IME)
- whenever the vendor payment or cost share is terminated (except for discharges to another nursing home).

The reconciliation month is the first month of a new averaging period.

Reconciliation should be completed in the system using the RECO screen. Refer to the SUCCESS User Manual for instructions. The following instructions are for completing manual reconciliation.

Step 1 Verify the actual income received by the individual for each month of the just completed three month averaging period.

Step 2 Determine the total gross income for each month separately. Round each monthly total down to the nearest dollar.

Step 3 Combine the three rounded monthly totals from Step 2 to determine the total actual income which should have been used in the just completed averaging period.

Step 4 Combine the three projected average monthly incomes used in the just completed averaging period to determine the total projected income.

Step 5 Compare the total projected income from Step 4 to the total amount from Step 3.

If the total actual income is greater than the total projected income, add the difference in actual income and projected income from the income for the first month of the new averaging period (see Step 9).

If the total actual income is less than the total projected income, subtract the difference in actual income and projected income from the income for the first month of the new averaging period (see Step 9).

Step 6 Repeat Steps 1 through 4, using IMEs instead of income. Use only IMEs which have been verified timely to determine actual IME. Round each IME total **up** to the nearest dollar.

PROCEDURES (cont.)

Step 7 Compare the total projected IME with the total actual IME.

If the total actual IME is greater than the total projected IME, add the difference in actual IME and projected IME to the IME deduction for the first month of the new averaging period (see Step 9).

If the total actual IME is less than the actual projected IME, subtract the difference in actual IME and projected IME from the IME deduction for the first month of the new averaging period (see Step 9).

Step 8 Use the averaging procedures previously explained to determine new projected averages for both income and IME to use in the new averaging period.

Step 9 Complete a patient liability budget for the first month of the new averaging period.

- Add the income reconciliation amount from Step 5 to the new projected average income used in the patient liability budget for the first month of the new averaging period.
- Add the IME reconciliation amount from Step 7 to the new projected average IME amount used in the patient liability budget for the first month of the new ongoing budget period.

Step 10 Complete patient liability budgets for the second and third months of the new ongoing budget period using the new projected average income and IME amounts.

Step 11 Complete appropriate fields in the computer system to calculate the new patient liability for the months of the new averaging period. Notify the A/R and PR via system generated notice of the change in monthly patient liability.

Patient Liability Income/ IME Calculation Sheet Use the Patient Liability Income/IME Calculation Sheet to manually calculate the actual monthly income and IMEs to be used to determine the average income and IMEs. This process would only be used if the appropriate fields in the computer system are not being used to calculate IME's.

Step 1 Total the monthly income and IMEs for each month of the averaging period as instructed on the form.

PROCEDURES (cont.)

Patient Liability Income/IME Calculation Sheet (cont.)

Step 2 Use the total monthly income and IME amounts on the patient Liability Income/IME Averaging/Reconciliation Worksheet to determine the average income/IME amounts and income/IME reconciliation amounts to be used in the patient liability budgets for the averaging period.

Patient Liability Income/ IME Averaging/ Reconciliation Worksheet

Follow the steps below to complete the Patient Liability Income/IME Averaging/Reconciliation Worksheet:

Step 1 Total the average income/IME used in the patient liability budgets for the averaging period in Columns A and D.

Total the actual income/IME used in the patient liability budgets for the averaging period in Columns B and E.

Step 2 Subtract the total actual income (4B) from the total average income (4A) to determine the income reconciliation amount (4C).

- If 4C is a positive number, subtract the amount in 4C from the income used in the patient liability budget for the first month of the new averaging period.
- If 4C is a negative number, add the amount in 4C to the income used in the patient liability budget period for the first month of the new averaging period.

Subtract the total actual IME (4E) from the total average IME (4D) to determine the IME reconciliation amount (4F).

- If 4F is a positive number, subtract the amount in 4F from the IME used in the patient liability budget for the first month of the new averaging period.
- If 4F is a negative number, add the amount in 4F to the IME used in the patient liability budget for the month of the new averaging period.

Step 3 Divide the total income/IME amounts (4B and 4E) by the number of months in the just completed averaging period to determine the average income/IME to use in the patient liability budget(s) for the new averaging period (5B and 5E).

2558 - SIGNIFICANT CHANGE IN INCOME OR IME

POLICY STATEMENT	A significant change is a change in either income or IME that was not considered when determining the projected averages.
BASIC CONSIDERATIONS	A significant change occurs when there is a $20 or more change in income or IME. Significant changes include the following: • a change in regular, recurring income • receipt of lump sum income • a change in regular, recurring IMEs • a one-time medical expense.
PROCEDURES	Complete reconciliation and start a new three month averaging period when a significant change is reported or discovered. If timely notice can be given in the month in with the change occurs, complete the following actions: • begin a new averaging period and complete reconciliation in the month of the change. • Include the amount of both the one time income/IME and recurring income/IME as part of the projected average income/IME for the new averaging period. If timely notice cannot be given in the month in which the change occurs, complete the following actions: • Begin a new averaging period and complete reconciliation in the earliest month for which notice can be given. • Include the entire amount of any one time income or IME as part of the reconciliation amount but not as part of the projected average income/IME for the new averaging period. • Determine the new projected average income/IME based on the amounts of recurring income/IME. **NOTE:** Do not include income or IMEs in reconciliation that were received or incurred more than three months prior to the month of reconciliation.

PROCEDURES (cont.)

Client Notification

Send notice to the A/R of an increase in patient liability/cost share via the system-generated notice.

Send notice to the A/R of termination of service (vendor payment/eligibility termination) no later than ten days prior to the first day of the effective month.

Use the following chart to determine the required action when a significant change is reported:

Chart 2558.1 - Required Action Based on a Significant Change

IF	THEN
notice can be given in the month the unexpected income is received or the large unexpected IME is incurred	begin a new averaging period and include the expense or income as part of the averaged projection for the new three month averaging period.
notice cannot be given in the month the income is received or the large IME is incurred	include the income or IME as a reconciliation amount at the beginning of a new three month averaging period, to begin with the earliest month in which notice can be given.
the income reconciliation amount exceeds the Medicaid billing rate for the nursing home where the A/R resides	do not charge more than the billing rate as patient liability for the reconciliation month. Any remaining income is a resource for the following month. **EXCEPTION:** If the recipient receives VA A&A, refer to Section 2556, VA Aid and Attendance.
the IME reconciliation amount or average IME exceeds the A/R's monthly income	do not carry the IME over to any future averaging period.

2559 - PATIENT LIABILITY/COST SHARE BUDGETING

POLICY STATEMENT	A patient liability/cost share budget is completed on all Medicaid recipients in a nursing home (NH) CCSP, ICWP or MRWP/CHSS.
BASIC CONSIDERATIONS	A patient liability/cost share budget is completed at the following times: • at approval of the application - to calculate the patient liability for the first month of eligibility - to remove the protection of income deduction • to remove the Medicare premium deduction • when a change in income occurs • when a change in incurred medical expenses (IME) occurs • at the beginning of each new averaging period.
PROCEDURES	Follow the steps below to complete the patient liability.
Step 1	Complete appropriate system fields to determine the amount of the A/R's income to divert to his/her spouse/dependents at home. • Refer to Section 2554, Diversion of Income, for the correct maintenance need standard to use. • Use the ADJUSTED GROSS income of the spouse/dependents, including In-Kind Support and Maintenance (ISM) received by the spouse/dependents. Refer to Section 2415, In-Kind Support and Maintenance.
Step 2	If the recipient is Medicaid eligible as ABD Medically Needy (AMN) and actual IMEs are allowed in the patient liability budget, complete Section B of Form 968 to calculate the actual IMEs. Refer to Section 2555, Incurred Medical Expenses. If the recipient is Medicaid eligible under the Nursing Home, CCSP , ICWP or MRWP/CHSS classes of assistance, use average income and IMEs in the patient liability budget. Refer to Section 2557, Averaging Income and Incurred Medical expenses. Proceed to Step 3.

PROCEDURES (cont.)

Step 3 Complete the appropriate fields to allow the system to accurately calculate patient liability/cost share. Complete Section C of Form 968 if a manual budget is used to calculate patient liability/cost share.

- Refer to Section 2552, Patient Liability Cost Share Deductions, for information on the deductions subtracted.
- Refer to Section 2556, VA Aid and Attendance, for information on including VA Aid and Attendance payments in the budget.

SPECIAL CONSIDERATIONS

CCSP to Nursing Home Compute a CCSP cost share for the month a recipient enters a nursing home from CCSP. There is no patient liability for the month of nursing home admission.

Nursing Home to CCSP Re-calculate the nursing home patient liability for the month an A/R goes into CCSP from a nursing home using the FBR as the PNA. There is no cost share for the month of admission to CCSP.

Transfer from out of state Nursing Home to Georgia Nursing Home When an A/R transfers directly from an out of state nursing home to a nursing home in Georgia, calculate the patient liability for the month of admission using the actual payment made to the out of state nursing home as an IME.

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2576 – VENDOR PAYMENT AUTHORIZATION

POLICY STATEMENT

A payment to the nursing home (NH) to cover the cost of care can be authorized when Medicaid eligibility has been approved. This Medicaid payment for NH care is called a vendor payment.

BASIC CONSIDERATIONS

The vendor payment is authorized by DFCS by entering pertinent data into the computer system.

Form DMA-59

At application, Form DMA-59 is prepared by the NH and sent to DFCS with the following information completed:

- The recipient's identifying information in Section I
- The **Level of Care** and **Patient Admitted From** fields in Section II.

Form DMA-59 must be typed, signed by the NH administrator (initial application only) and dated.

Prepayments and deposits may be required by a NH for an individual not already receiving Medicaid on the date of admission.

Refunds of Prepayments or Deposits Made to Nursing Homes by Medicaid Applicants

The facility must return such deposits to the individual or his/her family after eligibility for Medicaid is established. The refund, if made to the patient, is not counted as income to the individual in determining eligibility or patient liability but is considered a resource to the patient at the time of application.

PROCEDURES

Authorize the NH vendor payment by entering all pertinent data on the INST screen in SUCCESS. This information will be passed to DMA via the interface.

DFCS is not required to return a copy of the initial DMA-59 to the nursing home when the case is approved and vendor payment is authorized.

PROCEDURES
(cont.)

Use the following table to determine the first Payment Effective Date to enter in the system:

Chart 2576.1 – Determining the First Payment Effective Date of an NH Vendor Payment

IF the A/R is	THEN the first Payment Effective Date entered in the system is
a Medicaid recipient under any class of assistance upon admission to the NH AND has no VA third party contracts	the date indicated at the bottom of Form DMA-6 as the **Payment Date** or the date of admission, whichever is later.
not a Medicaid recipient* upon admission to the NH AND has no VA third party contracts **NOTE:** This includes QMB and SLMB recipients.	the **latest** of the following dates: • the date indicated at the bottom of Form DMA-6 as the **Payment Date**. • the beginning date of Medicaid eligibility. • the first Medicaid eligible day of any month for which the facility has not been paid in full or agrees to make a refund to the patient or family.
a Medicaid recipient in an NH AND a VA third party contract is paying the cost of care	the first day after the VA third party contract benefits are exhausted or terminated. **NOTE:** A/R can be Medicaid eligible, but no VP is authorized to the NH while the A/R is under a VA contract. The NH will notify DFCS when the contract expires.

NOTE: The first Payment Effective Date entered in the system **CANNOT** pre-date the effective date of Medicaid eligibility.

VA Aid and Attendance	Code income from VA Aid and Attendance appropriately in the system since it is no longer included in patient liability or eligibility determinations.
QMB Eligibility	A/R's in the NH who are QMB eligible should be approved for QMB in the system as a separate Assistance Unit.
Changes	On the INST screen enter the Level of Care in the LOC Authorization field and the Payment Authorization and Termination Dates. **NOTE:** If the DMA-6 indicates a permanent placement, enter 12/12/12 as the Payment Termination Date. Refer to Section 2577 for more information on Limited Stays.

PROCEDURES (cont.)	
Terminations	Terminate the vendor payment by completing the appropriate fields in the system. It is not necessary to submit a DMA-59 to DMA or the nursing home.
Notification	Notify the recipient and personal representative of the effective date of the vendor payment and the patient liability amounts via the system generated notice. Process changes in the system to allow timely notice before the end of the month for which an increase in patient liability or termination of the vendor payment is to be effective. **NOTE:** It is not necessary for the nursing home to send a discharge DMA-59 to DFCS if the A/R is discharged to the hospital and readmitted to the same nursing home, even if the hospital stay exceeds seven days. The nursing home should notify DFCS via DMA-59 if the A/R discharges to another nursing home, home, dies, or becomes otherwise ineligible. However, should DFCS become aware of such a discharge, a DMA-59 is not mandatory to process the change as long as known information is validated.

2577 – LIMITED STAY

POLICY STATEMENT	The Georgia Medical Care Foundation (GMCF) approves a nursing facility level of care (LOC) for a specified number of days based on an individual's physical and mental condition.
BASIC CONSIDERATIONS	GMCF authorizes limited stays by approving a LOC for a specified number of days on Form DMA-6. A nursing home (NH) vendor payment can only be authorized for the length of time specified on Form DMA-6. The NH must request approval from GMCF for continued placement by completing a new DMA-6 when the original length of stay has expired.
PROCEDURES	Follow the steps below to authorize a vendor payment for a limited stay:
Step 1	Screen every Form DMA-6 for a limited stay when it arrives at the DFCS office from GMCF.
Step 2	Authorize and terminate the vendor payment for the stay (number of days) indicated on Form DMA-6 by completing the appropriate fields on the INST screen in SUCCESS. Authorize a vendor payment using either a private pay or Medicaid Form DMA-6 or a combination of the two. Do not authorize a vendor payment for any day(s) not covered by a Form DMA-6. • Refer to Chart 2576.1 – Determining the First Payment Effective Date of a NH Vendor Payment to determine the first Payment Authorization Date to enter on the INST screen. • Enter the day after the last day of the stay approved on Form DMA-6 as the Payment Termination Date of the vendor payment termination. • Enter the appropriate Payment Reason code.
Step 3	Notify the A/R or PR and NH via the system generated notice of the extended level of care dates.

PROCEDURES (cont.)

Step 4 If another Form DMA-6 is received indicating that GMCF has approved additional days for the limited stay, approve an extension of the vendor payment in the system by entering the new information on the INST screen. File the new Form DMA-6 in the case record.

Refer to Chart 2577.1 – Extending the Limited Stay. Notify the A/R of the extension of the vendor payment via the system-generated notice.

If another Form DMA-6 is not received prior to the termination of the Level of Care, complete a CMD. Refer to Section 2055, Continuing Medicaid Determination.

NOTE: If Medicaid is terminated as a result of the CMD and a Form DMA-6 is subsequently received within 30 days of the termination date on the system, reopen the case as closed in error. If a new Form DMA-6 is received more than 30 days after the system termination date, process a new application.

NOTE: The limited stay has no effect on Medicaid eligibility for an A/R who is eligible under a class of assistance (COA) that does not require the A/R to meet the length of stay (LOS) and level of care (LOC) basic eligibility criteria.

NOTE: If GMCF denies the NH's request for an additional stay, DMA will notify DFCS of the denial with a form letter.

PROCEDURES
(cont.)

Use the following chart to determine the specific actions to be taken based on whether the NH requests an additional stay and the action take by GMCF:

Chart 2577.1 – Extending the Limited Stay	
IF	**THEN**
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** the receipt of a second Form DMA-6 indicates that an additional stay has been approved by GMCF and there is **no** gap in coverage or change in LOC	authorize the vendor payment for the additional stay by completing the appropriate fields on the INST screen for every affected benefit month and changing the "Term Date" to the day following the end date of the new DMA-6 or related form.
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** there **is** a gap in days between the end date of the old DMA-6 and the payment date of the new DMA-6	authorize the vendor payment for the additional stay for every affected benefit month by completing the appropriate fields on the INST screen. Enter a "Discharge Date" that is the same as the original "Payment Term Date." Complete a second line for the new NH information below the existing line of NH information. The admission date will be the new DMA-6 payment date.
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** the receipt of the second DMA-6 indicates there **is** a change in the LOC	authorize the vendor payment for the additional stay and change in LOC for every affected benefit month by completing the appropriate fields on the INST screen. Change the LOC to the appropriate new code and update the "Payment Auth Date" to the payment date and the "Payment Term Date" to the day after the end date on the new DMA-6.
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** an additional stay has been requested but denied by GMCF	terminate Medicaid under the Nursing Home or AMN Nursing Home COAs and complete a CMD.

PROCEDURES
(cont.)

Chart 2577.1 – Extending the Limited Stay (cont.)

IF	THEN
the approved stay expires **prior to** disposition of the application and initial vendor payment authorization **AND** the receipt of a second Form DMA-6 indicates that an additional period of time has been approved by GMCF	approve retroactive and/or ongoing Medicaid for the month(s) of the limited stay(s) **AND** authorize the vendor payment for the limited stays approved on the two Forms DMA-6s. use the ending date on the second Form DMA-6 as the Payment Termination Date in the system.
the approved stay expires **prior to** disposition of the application and initial vendor payment authorization **AND** the NH has **not** requested an additional stay **OR** an additional stay has been requested but denied by GMCF	deny ongoing Medicaid under the Nursing Home or AMN Nursing Home COAs and complete a CMD **AND** approve retroactive Medicaid for the month(s) of the original stay, if eligible **AND** authorize the vendor payment in the system for the limited stay approved on Form DMA-6.

2578 – SSI RECIPIENTS

POLICY STATEMENT

An individual who receives SSI prior to admission to a nursing home (NH) has already had Medicaid eligibility established. A NH vendor payment can be authorized.

BASIC CONSIDERATIONS

A NH vendor payment can be authorized for the SSI recipient entering a NH if all the following conditions are met:

- The A/R is a resident of Georgia.
- The A/R has an approved Level of Care (LOC).
- The A/R has not transferred a resource for less than fair market value within 36 months prior to the month of application.

Individuals entering a NH who receive SSI only will have their SSI payment amount reduced to $30.00.

Individuals entering a NH who receive more than the LA-D FBR in monthly income from another source will have their SSI terminated and changed automatically to ABD Medicaid on the DMA Recipient Data Base. Refer to Section 2748, SSI/DMP to MAO List.

NOTE: Authorization of a vendor payment for a SSI recipient should not be delayed pending receipt of the SSI/DMP to MAO list.

PROCEDURES

Follow the steps below to authorize a NH vendor payment on a SSI recipient:

Step 1 Complete and submit Form 107 to the SSA District office to report the SSI recipient's new living arrangement and address.

Step 2 Register, verify and document all income on the system.

Step 3 Obtain A/R's or PR's statement regarding ownership of resources and possible transfer of assets. Refer to Section 2342, Transfer of Resources.

NOTE: If a SSI only A/R's countable resources exceed the SSI resource limit, notate on Form 107 for SSA's information.

Step 4 Determine patient liability for the month of admission to LA-D using ALL income available to the A/R that month, INCLUDING SSI.

Determine patient liability for the month(s) following the month of admission to LA-D using only the amount of SSI to which the recipient is entitled in LA-D (if any) plus all other income.

PROCEDURES (cont.)

Step 4 (cont.) NOTE: The month of admission to LA-D means the first month of continuous confinement in LA-D, including situations where the SSI recipient entered the NH from a hospital or other LA-D.

Step 5 Authorize the vendor payment on the system and send notice to the A/R and/or PR and the NH.

Use the payment date on Form DMA-6 as the effective date in the system.

SPECIAL CONSIDERATIONS

SSI Recipient is not a Resident of Georgia

Follow the procedures below if the SSI recipient entering a NH is not a resident of Georgia:

- Do **not** authorize a vendor payment.
- Notify DMA via Form 951 that the A/R is not a Georgia resident and therefore not eligible for Medicaid.
- Notify SSA via Form 107 of the A/R's correct state of residence.
- Notify the SSI recipient of his/her ineligibility for a vendor payment.

SSI Recipient is not in a GMCF Approved Level of Care

Follow the procedures below if the SSI recipient entering a NH is not in a GMCF approved LOC:

- Do **not** authorize a vendor payment.
- Notify the SSI recipient of his/her ineligibility for a vendor payment.

2579 – SSI 1619 INDIVIDUALS

POLICY STATEMENT	Section 1619 of Title XIX of the Social Security Act entitles certain blind and disabled individuals to receive SSI while employed.
BASIC CONSIDERATIONS	PL 99-643 created an exception to the rules regarding the treatment of SSI income for individuals eligible for SSI under Section 1619 (a) or 1619 (b) who entered a nursing home (NH) or CCSP. These individuals will remain eligible for SSI for the first two months in a NH or CCSP. The individual's SSI income is not considered in determining patient liability. Individuals eligible for SSI under Section 1619(a) and (b) are those disabled or blind individuals who are employed and have earned income the month preceding the month of admission to a NH or CCSP.
1619(a)	Individuals eligible under 1619(a) have earned income of less than $780 a month.
1691(b)	Individuals eligible under 1619(b) have earned income of more than $780 a month. These individuals may have too much income to receive an SSI payment but still receive Medicaid under an SSI ID number.
PROCEDURES	Verify the A/R's status under Section 1619 by requesting verification from SSA for any A/R who was employed the month prior to entering a NH or CCSP. Do not include any of the SSI income in the patient liability budget. Treat all other income under the usual rules for determining patient liability. Authorize the vendor payment to the NH. Refer to Section 2576, Vendor Payment Authorization.

2580 – SSI RECIPIENT TEMPORARILY IN A NURSING HOME

POLICY STATEMENT	Section 9115 of the Omnibus Budget Reconciliation Act amended the Social Security Act to entitle certain SSI individuals to retain their income for the month of admission to a nursing home (NH) and the following three full months.
BASIC CONSIDERATIONS	The SSI recipient must provide SSA with physician certification that the NH confinement should last no more than 90 days. S/he must also show a need to pay outside expenses to maintain their private living arrangements until s/he returns home. The NH and SSI recipients are responsible for providing the physician certification and documentation of living expenses to the Social Security Administration (SSA). The SSI recipient's income is not considered in determining patient liability for the month of admission and the following three full months in the NH.
PROCEDURES	Treat all SSI recipients entering a NH according to standard policy UNLESS written documentation from SSA identifies the individual as temporarily in an institution (LA-D). Follow the steps below to authorize a NH vendor payment if documentation is provided in writing by SSA to verify that the SSI recipient is temporarily in the NH.
Step 1	Authorize the vendor payment to the NH. There is no patient liability for the month of admission and the following three months. Refer to Section 2576, Vendor Payment Authorization.
Step 2	Generate an alert to review the case toward the end of the third full month of the SSI recipient's NH confinement.
Step 3	If the individual remains in the NH in the fourth month after the month of admission, determine patient liability according to regular policy and procedures.

2581 – SWING BEDS

POLICY STATEMENT	Designated small rural hospitals are allowed to assign certain hospital beds as nursing facility beds, called swing beds.
BASIC CONSIDERATIONS	Hospitals approved as swing bed providers must have a provider number, which ends in S. The swing bed hospital is required to obtain a level of care (LOC) approval on Form DMA-6 from GMCF. If an A/R is confined to a nursing home or swing bed, the application is processed in the county where the nursing home/swing bed is located. However, if at the time the application is received the A/R is no longer in that facility, the county where the A/R currently resides processes the application.
PROCEDURES	Follow the steps below to authorize a vendor payment for an individual placed in a swing bed:
Step 1	If the individual is receiving Medicaid when s/he is placed in the swing bed, proceed to Step 2. If the individual is **not** receiving Medicaid when s/he is placed in the swing bed, determine his/her Medicaid eligibility under the Nursing Home or ABD Medically Needy classes of assistance (COA). **NOTE:** If Medicaid eligibility is determined under the Nursing Home COA, add a statement to the system generated approval notice informing the recipient that Medicaid is approved only through the month in which the swing bed/LOC approval expires unless the recipient is moved to an NH.
Step 2	Verify the approval of a skilled or intermediate level of care with a Form Dma-6 stamped by GMCF as Skilled or IC LOC upon admission to the swing bed.
Step 3	Determine the recipient patient's liability for the period of time approved for a LOC on Form DMA-6.
Step 4	Notify the A/R of the patient liability for each approved month.

PROCEDURES (cont.)

Step 5 Authorize the vendor payment using the procedures for authorizing a limited stay. Refer to Section 2577, Limited Stay.

NOTE: The NH must request an extension of the LOC approval with the receipt of a new Form DMA-6 at the following intervals:

- fourteen days following admission to the swing bed
- every 30 days thereafter.

The purpose of this special arrangement is to move the client to another appropriate place of care as soon as possible.

Step 6 If a new Form DMA-6 approving an extension of the LOC is received, approve an extension of the LOC. Refer to Chart 2577.1, Extending the Limited Stay. Notify the recipient of any change in patient liability.

If a new Form DMA-6 approving an extension of the LOC is not received by the day the previous approval expires and the A/R's COA is Nursing Home, CCSP, or ICWP, complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

2582 – TEMPORARY ABSENCE FROM NURSING HOME

POLICY STATEMENT	DMA will continue to make a vendor payment for a limited time on an individual residing away from the nursing home (NH) due to hospitalization or a home visit.
BASIC CONSIDERATIONS	DMA will continue to make a vendor payment for the actual number of days a bed is held for a recipient while hospitalized, up to a maximum of seven days per hospitalization. Arrangements can be made between the NH and the recipient to hold the bed longer than seven days. DMA will continue to make a vendor payment when a recipient visits away from the NH for a specified number of days, depending on the level of care (LOC) the recipient is receiving in the NH.

The following chart specifies the number of days DMA will continue the vendor payment to the NH during a home visit based on the LOC the recipient is receiving in the NH.

Chart 2582.1 – Temporary Absence from NH for a Home Visit

IF the recipient is	THEN the Vendor Payment will continue for
in a Skilled LOC	a maximum number of 8 days per calendar year with a maximum of 2 days per visit.
in a Intermediate LOC	a maximum of 16 days per calendar year with no maximum per visit.
in an ICF/MR LOC	a maximum of 30 days per calendar year with no maximum per visit.
a potential Alternative Health Services candidate under CCSP	up to 7 days for a trial visit in a Personal Care Home for a maximum of 2 visits per year.
in the hospital	up to 7 days

NOTE: A day is defined as an overnight stay away from the NH. A DFCS County Department that becomes aware that a facility is consistently disregarding the guidelines concerning absence should contact the state Medicaid Unit through their supervisor.

PROCEDURES

Medicaid will pay the NH for up to 7 hospital bed hold days when an A/R goes into the hospital and is expected to return to the nursing home.

When a recipient remains in the hospital for more than 7 days, assume that the NH has made arrangements with the recipient or family to hold the bed beyond 7 days.

NOTE: It is not necessary for the nursing home to send a discharge DMA-59 to DFCS if the A/R is discharged to the hospital and readmitted to the same nursing home, even if the hospital stay exceeds seven days.

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2600 – FAMILY MEDICAID ASSISTANCE UNITS OVERVIEW

POLICY STATEMENT	A Family Medicaid Assistance Unit (AU) includes individuals for whom assistance is requested and who receive benefits upon approval of the application. A Family Medicaid Budget Group (BG) includes the AU members and those household members who are financially responsible for AU members.
BASIC CONSIDERATIONS	The BG size determines the income limit in a Family Medicaid Class of Assistance (COA). The BG consists of the AU members, those included because of financial responsibility and other individuals included in order to increase the income limit. The income and resources of all individuals in the BG are used to determine eligibility. Because of financial responsibility, the income of certain individuals not included in the BG are considered when determining the AU's eligibility for certain COA's. Refer to Section 2661, Responsibility Budgeting.
PROCEDURES	Use the following criteria to determine the composition of an AU: • Identify all individuals living in the residence. • Determine who is requesting assistance. • Determine the relationship of the individuals requesting assistance to others living in the residence. • Determine whose income and resources are to be considered in determining eligibility for those individuals requesting assistance.

2610 - LOW INCOME MEDICAID ASSISTANCE UNITS

POLICY STATEMENT	The Low Income Medicaid (LIM) Assistance Unit (AU) includes individuals for whom Medicaid is requested and for whom Medicaid coverage is available.
BASIC CONSIDERATIONS	A child must be related to and living in the home with a specified relative in order to be included in the AU. The natural or adoptive parent(s) of a child for whom LIM has been requested must be included in the AU unless the parent receives SSI, is ineligible or penalized. The A/R may voluntarily exclude a child and his/her income and resources from the LIM AU. A child who has been voluntarily excluded from the LIM AU and who has a sibling included in the LIM AU cannot be included in another LIM AU but may have his/her eligibility determined under another Medicaid COA. A child who has been voluntarily excluded from the LIM AU and who does not have a sibling included in the LIM AU may receive LIM in another LIM AU. A child eligible for Newborn Medicaid may be included or excluded from the LIM AU at the option of the A/R. If the child is included in the LIM AU, the child retains his/her Newborn Medicaid eligibility. If the AU becomes ineligible for LIM during the child's first thirteen months, beginning with the birth month, the child continues to be eligible for Newborn Medicaid, provided the child has continuously lived with the mother. A non-parent relative or child who does not meet an eligibility requirement is excluded from the AU. The income and resources of the excluded individual are also excluded. The needs of an individual included in a LIM AU may also be included in another Family Medicaid BG. If the individual's needs are included in another Family Medicaid BG, his/her income and, if applicable, his/her resources are considered in determining eligibility for the other BG.

PROCEDURES

Follow the steps below to determine the composition of a LIM AU:

Step 1 Identify individuals living in the home.

Step 2 Exclude the following individuals from the AU:

- an individual who does not meet the citizenship/alienage requirement
- an individual who is penalized for failure to meet the enumeration, cooperation with CSE or TPR requirement
- an SSI recipient
- anyone who does not meet a point of basic eligibility, such as age or relationship.

Step 3 Identify and include the child(ren) for whom application is being made. Identify and include parents who have not been excluded in Step 2.

Step 4 Include the following individuals in the AU at the discretion of the A/R:

- children within the specified degree of relationship to the adult making the application
- one adult living in the home who is within the specified degree of relationship if there is no parent in the home or if the only parent in the home receives SSI.

If a child is added in Step 4, repeat Step 3.

NOTE: Siblings and half-siblings may be excluded from the LIM AU. An excluded child, however cannot be included in a separate LIM AU. RSM can be considered for the excluded child.

VERIFICATION

Accept the A/R's statement to determine who lives in the household, unless the information provided conflicts with other information available to the agency.

Use one of the following sources if verification is required.

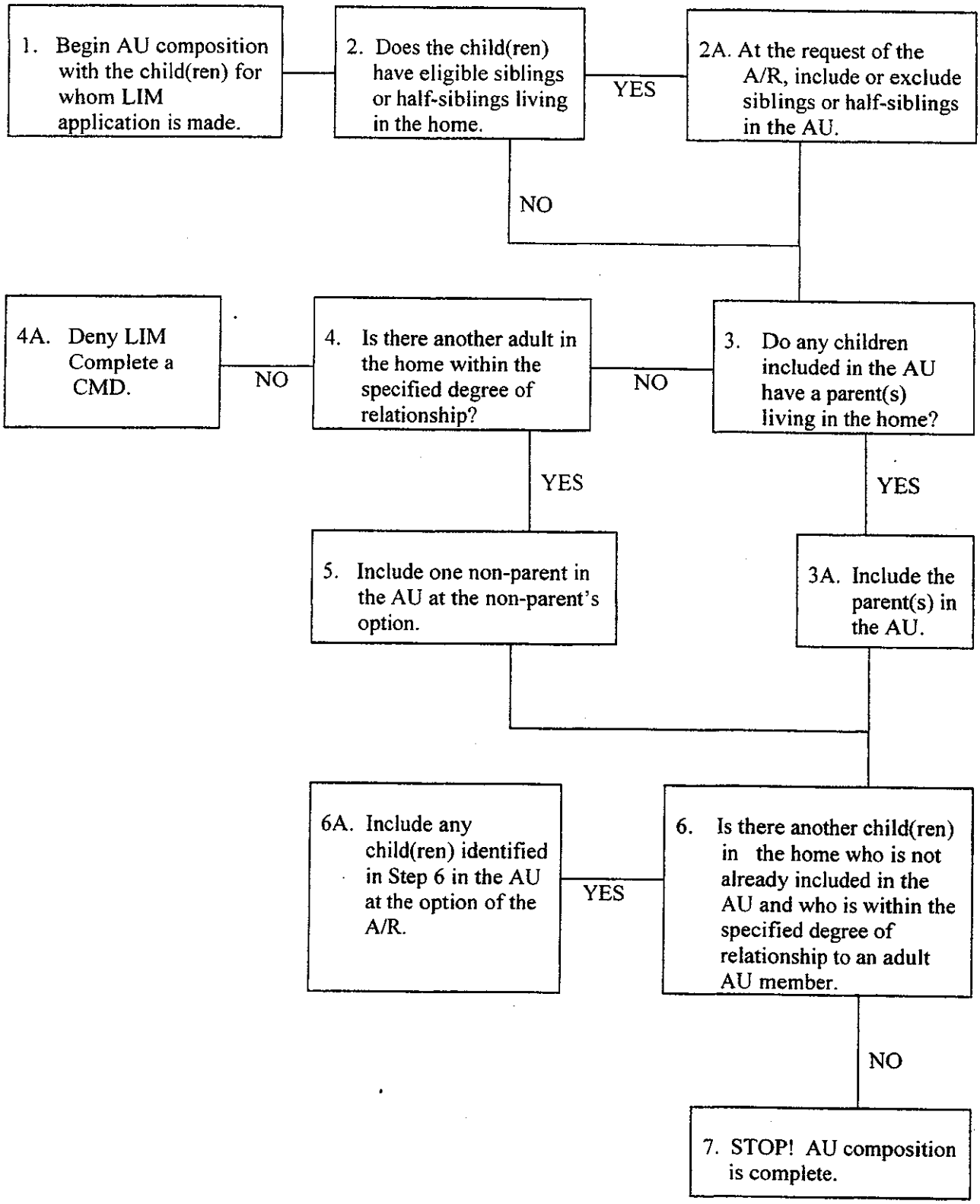
- a statement from the landlord
- a statement from a person outside the AU who has knowledge of the AU's situation
- any other sources which verify the AU's statement.

DOCUMENTATION

Document the following for each individual in the home:

- the name of every individual and their relationship to the A/R
- the reason the individual is included or not included as an AU member.

CHART 2610.1 - DETERMINING THE MEMBERS OF A LIM ASSISTANCE UNIT



Use the following chart to determine the composition of the LIM AU in special situations.

CHART 2610.2 - DETERMINING THE COMPOSITION OF A LIM AU	
SITUATION	**TREATMENT**
Adult is absent from the home because of treatment or training.	Include the adult in the AU when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the adult to the home AND • the adult continues to exercise care and control of the AU child(ren) AND • the adult wants to be included in the AU during the absence. **NOTE:** Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. Exclude the adult from the AU if any of the following conditions exist: • the adult is incarcerated • the adult is in a public institution.
Alien lives in the home.	Include the alien in the AU if s/he meets alien requirements and is required to be in the AU. Exclude if the alien requirements are not met. Refer to Section 2215, Citizenship/Alienage.
AU resides in a shelter.	Determine the AU composition of individuals residing in facilities such as homeless or battered women and children shelters as for any other group of related individuals who live together.

CHART 2610.2 - DETERMINING THE COMPOSITION OF A LIM AU (CONT.)	
SITUATION	**TREATMENT**
Biological parent lives in the home with the child who has been adopted AND the adoptive parent(s) is in the home.	Include the biological parent as a sibling only if both of the following conditions exist: • the biological parent is also the child (adoptive or natural) of the adoptive parent(s) AND • the biological parent meets the age requirements. Adoption terminates the legal responsibility of a parent.
Biological parent lives in the home with the child who has been adopted AND the adoptive parent(s) is not in the home.	Include the biological parent as the grantee relative if s/he is eligible and chooses to be included.. Adoption terminates the legal responsibility as a parent.
Biological parent whose parental rights have been terminated lives in the home with the child and a specified relative.	Include either the biological parent or the specified relative as the caretaker relative. Termination of parental rights severs legal responsibility to be included as a parent; therefore, the specified relative or the biological parent can choose to be included in the AU. **NOTE**: If the home is shared with a person who is not within the specified degree of relationship to the child, only the biological parent may be included as the caretaker relative.
Both parents live in the home with a mutual child.	Include both parents in the AU. **NOTE**: The parents do not have to be married to each other. If the mother was legally married to another man at the time of the child's birth, exclude the biological father living in the home unless paternity is established. Refer to Section 2640, Paternity.

CHART 2610.2 - DETERMINING THE COMPOSITION OF A LIM AU (CONT.)	
SITUATION	**TREATMENT**
Child is absent from the home because of treatment or training.	Include the child in the AU when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the child to the home AND • the care and control of the dependent child continue to be the responsibility of the caretaker relative AND • the caretaker or other eligible adult wants the child to be included in the AU. **NOTE:** Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. Exclude the child from the AU if any of the following conditions exists: • The child is incarcerated, including placement in a detention facility. • The child is placed in a public institution. • The child is placed in a private residential childcare institution such as GA Baptist Children's Home, United Methodist Children's Home or GA Sheriffs Boys' Ranch.
Child is placed in a private residential childcare institution such as GA Baptist Children's Home, United Methodist Children's Home or GA Sheriffs Boys' Ranch.	Ineligible for LIM. Complete a CMD.
Child lives with an individual who has legal custody and who is not within the degree of relationship.	Ineligible for LIM. Complete a CMD.

CHART 2610.2 - DETERMINING THE COMPOSITION OF A LIM AU (CONT.)	
SITUATION	**TREATMENT**
Couple lives together AND they are not married AND there is no eligible mutual child(ren) but each has a child.	Determine eligibility as separate AUs.
Dependent child is in and out of the home.	Include the dependent child in the AU when the absence is to be temporary and care and control of the dependent child remains with the A/R.
Individual is required to be in multiple AUs.	Combine all individuals involved into one AU if an individual is required by policy to be in more than one AU.
Married couple has no eligible mutual child(ren) but each has a child.	Determine the option that is most advantageous to the family. Combine into one AU or make separate AUs.
Minor parent (no spouse) lives in the home with his/her parents.	Include the minor parent as a **dependent child** if one of the following conditions exists: • The minor's sibling(s) are included in the AU. • The minor's parent chooses to be included as a caretaker. **NOTE:** The AU may choose to include or exclude the minor's child. Include the minor parent as **caretaker** if the minor lives with his/her parent(s) who does not receive LIM for the minor's sibling(s).

CHART 2610.2 - DETERMINING THE COMPOSITION OF A LIM AU (CONT.)	
SITUATION	**TREATMENT**
Minor parent and his/her spouse live in the home with her parents.	Include the minor parent as a **dependent child** if one of the following conditions exists: • The minor's sibling(s) are included in the AU. • The minor's parent(s) are included as a caretaker. DO NOT include the minor's spouse in the AU unless his/her child is included in the AU. Consider his/her income in determining eligibility. Refer to Section 2661, Responsibility Budgeting. **NOTE:** The AU may choose to include or exclude the minor's child. Include the minor as a **caretaker** if the minor lives with his/her parent(s) who does not receive LIM for the minor's sibling. Include the minor's spouse in the AU if s/he is the parent of the minor's child and the child is deprived.
Parent is in and out of the home	Include a parent who appears to reside in the home based on any of the following indicators: • The parent has no other residence. • The parent lists the home as his/her address. • The parent shares in household expenses. Exclude a parent who appears to visit the home based on any of the following: • The parent does not share in household expenses. • The parent has a specific time frame for his/her visits. • The parent maintains another residence. **NOTE:** Thoroughly document the case record to substantiate the exclusion/inclusion of the parent.
Only dependent child(ren) receives SSI	Determine the child's eligibility on all points other than financial need. Include only the eligible caretaker and other eligible adult (if applicable) in the AU. **NOTE:** The income/resources of a SSI child(ren) are not considered when determining LIM eligibility.

CHART 2610.2 - DETERMINING THE COMPOSITION OF A LIM AU (CONT.)	
SITUATION	**TREATMENT**
Parents live in the home with the child(ren) and a specified relative who has legal custody of the child(ren) (parental rights have not been terminated).	Include the parent in the AU as the caretaker relative. Designate the relative with legal custody as the responsible party if it is not in the best interest for the parent to be the responsible party.
Roomer or boarder lives with the AU.	Determine the AU composition without regard to others living with the AU and paying a fee for food and/or shelter.
Stepparent lives in the home AND the stepparent has no children of his own living in the home.	Include the stepparent in the AU (at the stepparent's option) if one of the following situations exists: • there is no parent living in the home • the parent in the home receives SSI. Exclude the stepparent if a non-SSI parent lives in the home. Consider a portion of the stepparent's income. Refer to Section 2661, Responsibility Budgeting.

2620 - ASSISTANCE UNITS OTHER THAN LIM

POLICY STATEMENT

The Family Medicaid Assistance Unit (AU) includes individuals for whom Medicaid is requested and for whom Medicaid coverage is available.

BASIC CONSIDERATIONS

Certain individuals living in the home are included in the eligibility determination for the AU members. These individuals as well as all the AU members comprise the Budget Group (BG).

In all Medicaid Classes of Assistance (COAs), only the AU members receive Medicaid upon approval of the application.

Budget Group Composition

The BG consists of the following individuals:

- all AU members
- parents of BG children living in the home with the AU

  NOTE: If there is a legal father, refer to Chart 2620.1, Determining the Composition of a Non-LIM AU and/or BG.

- the legal spouse of a pregnant woman living in the home
- ineligible aliens who meet all eligibility requirements except citizenship and enumeration

  NOTE: An ineligible alien can be part of the AU only under Emergency Medical Assistance (EMA). Refer to Section 2054, EMA.

- others who meet LIM relationship requirements and who choose to be included.

The BG size determines the income limit and, if applicable, the resource limits for a Family Medicaid COA. The income and resources, if counted, of all individuals in the BG are used to determine eligibility.

If a pregnant woman requests or receives Medicaid under RSM Pregnant Woman Medicaid, the unborn child is included in the BG.

NOTE: The unborn child is not included in the BG if the pregnant woman is a minor requesting Medicaid under RSM Child Medicaid.

The BG size is increased accordingly if it is medically verified that the pregnant woman is carrying more than one fetus.

BASIC CONSIDERATIONS

Budget Group Composition (cont.)

The reputed father of the unborn child living with a pregnant woman is included in the BG only if he and the pregnant woman are married or he and the pregnant woman have a mutual child(ren), for whom paternity has been established, included in the BG. Refer to Section 2640, Paternity.

Children in the same BG can have Medicaid eligibility determined under any Medicaid COA. The composition of the BG for each child does not change, even if each child's eligibility is determined under a different Medicaid COA.

EXCEPTION: Four Months Medicaid (4MCS) and TMA do not require the same BG composition. Refer to the appropriate section in Chapter 2100, Classes of Assistance.

A parent may choose to exclude his/her child from a Medicaid AU and/or BG. If excluded, the child cannot be included in any other Medicaid AU/BG of the same COA.

NOTE: The parent(s)' income cannot be allocated to meet the needs of an excluded child.

A child receiving Medicaid under Newborn coverage may or may not be included in a Medicaid BG, at the option of the A/R.

PROCEDURES

Follow the steps below to determine the composition of the Medicaid AU and BG:

Step 1 Determine the person(s) for whom Medicaid is requested.

Step 2 Include in the AU only those individuals in Step 1 for whom Medicaid coverage is available under any Medicaid COA. Refer to Chapter 2100, Classes of Assistance.

Step 3 Include the following individuals living in the home:

- the parents of any existing children in the AU/BG for whom paternity has been established

  NOTE: Refer to Section 2640, Paternity, if a legal father exists and the biological father is in the home.

- the legal spouse of a pregnant AU member.

PROCEDURES (cont.)

Step 4 Determine if there are others who may be included in the AU and/or BG, such as the following:

- siblings or half-siblings
- other children living in the home who are within the LIM degree of relationship to an adult in the BG
- one non-parent adult relative who is a caretaker (aunt, uncle, grandparent, etc.) if there is no parent in the home.

If the sibling/half-sibling(s) or other children meet all eligibility requirements for the COA, include the child(ren) in the BG, at the A/R's option.

If the sibling/half-sibling or other children do not meet all eligibility requirements for the COA, include the child(ren) in the BG at the A/R's option, to increase the income limit.

Step 5 Include in the BG the parents of any children included in the AU or BG in Step 4. Include only the parents who live in the home with their children.

Exclude the following individuals from the AU and BG:

- a SSI recipient
- the parent(s) of a pregnant minor applying for Medicaid as a pregnant woman
- the father of an unborn child **unless** he is married to the pregnant woman.

  NOTE: The father of an unborn child **may** be included in the BG of a pregnant woman if he is not married to the pregnant woman **and** they have a mutual child in the BG.

- a stepparent, unless s/he is the caretaker of biological or adopted children in the BG

PROCEDURES

Step 5 (cont.)

- an individual who fails to apply for other benefits for which s/he may be entitled as noted below

  - If the potential benefit is for a parent, exclude the parent and everyone for whom s/he is financially responsible
  - If the potential benefit is for a child, exclude the child only.

- a minor sibling/half-sibling who is voluntarily excluded by the A/R from another AU and/or BG to avoid consideration of the child's income and/or resources.

Step 6

Exclude the following individuals from the Medicaid AU but **include** them in the Medicaid BG:

- an adult who fails to cooperate with CSE or TPR requirements

  NOTE: A child is never excluded from the AU because of an adult's failure to cooperate with CSE or TPR.

- an individual who does not meet the citizenship or eligible alien status requirements

  EXCEPTION: EMA

- an adult who fails to cooperate with the enumeration requirement for him/herself.

  EXCEPTION: An individual who is not a citizen or an eligible alien is not required to meet the enumeration requirement.

Use the following chart to determine composition of the AU and BG:

NOTE: The term *minor* or *child* used in this chart includes 18 year olds who are eligible for Medicaid.

CHART 2620.1 - DETERMINING THE COMPOSITON OF A NON-LIM AU AND/OR BG

SITUATION	TREATMENT
Adult is absent from the home because of treatment or training.	**Include** the adult in the AU and/or BG when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the adults to the home AND • the adult continues to exercise care and control of the AU child(ren) AND • the adult wants to be included in the AU and BG during the absence and is eligible to be included. **NOTE:** Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. **Exclude** the adult from the AU and/or BG if any of the following conditions exists: • The adult is incarcerated. • The adult is in a public institution. • The adult is legally committed to an institution. Refer to Section 2066, Placement Outside the Home.
Adult (parent, spouse or grantee relative) is absent from the home because of duty in the uniformed forces of the United States.	Exclude from the BG and AU. Budget any income sent to the Medicaid BG from the parent as child support if there are existing children or as a contribution if the money is sent to a pregnant woman from the reputed father of an unborn child.

CHART 2620.1 (CONT.) - DETERMINING THE COMPOSITON OF A NON-LIM AU AND/OR BG	
SITUATION	**TREATMENT**
Biological parent lives in the home with the child who has been adopted AND the adoptive parent(s) is in the home.	Include the biological parent as a sibling of the adoptive child only if both of the following conditions exist: • the biological parent is also the child (adoptive or natural) of the adoptive parent(s) AND • the biological parent meets the age requirement In this situation, adoption terminates the parental relationship.
Biological parent lives in the home with the child who has been adopted AND the adoptive parent(s) is **not** in the home.	Include the biological parent as the grantee relative if s/he is eligible and chooses to be included. In this situation, adoption terminates the parental relationship.
Biological parent whose parental rights have been terminated lives in the home with the child and a specified relative of the child.	Include either the biological parent or the specified relative as the caretaker relative. Termination of parental rights serves the legal requirement to be included as a parent; therefore, the specified relative or the biological parent can choose to be included in the AU. **NOTE:** If the home is shared with an individual who is not within the specified degree of relationship to the child, then only the biological parent may be included as the caretaker relative.
Both parents live in the home with a mutual child.	Include both parents in the AU and/or BG.

CHART 2620.1 (CONT.) - DETERMINING THE COMPOSITON OF A NON-LIM AU AND/OR BG (CONT.)	
SITUATION	**TREATMENT**
Child is absent from the home because of treatment or training.	Include the child in the AU when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the child to the home AND • the care and control of the dependent child continues to be the responsibility of the caretaker relative AND • the caretaker or other eligible adult wants the child to be included in the AU. **NOTE:** Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. **NOTE:** Refer to Section 2066, in Placement Outside the Home.
Child is placed in a residential dependent care institution, such as GA Baptist Children's Home, United Methodist Children's Home or GA Sheriffs Boys' ranch.	Consider the child an AU of one and determine the child's Medicaid eligibility if the following conditions are met: • the center is privately owned and operated OR • the center is a public facility and the placement is temporary pending other arrangements appropriate to the child's needs. **NOTE**: Refer to Section 2066, Placement Outside the Home.
Child lives alone.	Consider the child to be an AU of one and determine his/her eligibility for RSM or MN.
Child lives with a legal guardian who is not within the LIM degree of relationship.	Determine Medicaid eligibility for the child under the appropriate COA. Exclude the legal guardian from the AU and BG.

CHART 2620.1 (CONT.) – DETERMINING THE COMPOSITON OF A NON-LIM AU AND/OR BG	
SITUATION	**TREATMENT**
Child lives with an individual who has legal custody only (not a legal guardian and not within the degree of relationship).	Determine Medicaid eligibility for the child under the appropriate COA. Exclude the individual with legal custody from the AU and BG.
Parent(s) is required to be in multiple BGs.	Include the parent(s) in each BG. **Example:** A parent has a 5-year-old and a 14-year-old. The 5-year-old is RSM income eligible but the 14-year-old is not. When MN is considered for the 14-year-old, the parent(s) is included in both the RSM and MN BGs. The parents **must** be included in both BGs.
Married couple has no mutual children, but they each have a child.	Establish separate BGs and AUs.
Minor parent lives in the home with his/her parent(s).	Minor parent needs Medicaid: include the minor parent as a child with his/her parents in the BG and/or AU. The AU may choose to include or exclude the minor's child. Minor parent's child needs Medicaid: Include the minor parent in the BG and/or AU as an adult if the minor parent's parent does not receive LIM for his/her siblings **and** his/her parent(s) chooses not to be included in the BG. Refer to Section 2661, Responsibility Budgeting, unless the COA is RSM.
Married minor lives with his/her parent(s) and applies for Medicaid as a child.	Include the married minor in the BG as a child with his/her parents. If s/he has a spouse also living in the home, refer to Chapter 2650, Family Medicaid Budgeting.
Married minor lives with his/her spouse and applies for Medicaid as a child.	Married minor is an AU of one because s/he is considered a child but the spouse is financially responsible. If the spouse is also a minor, there can be separate AUs. Refer to Section 2661, Responsibility Budgeting, to determine what income from the spouse is deemed to the AU or the allocation is appropriate.

CHART 2620.1 (CONT.) – DETERMINING THE COMPOSITON OF A NON-LIM AU AND/OR BG	
SITUATION	**TREATMENT**
Parent is in and out of the home.	**Include** a parent who appears to reside in the home based on any of the following indicators: • The parent has no other residence. • The parent lists the home as his/her address. • The parent shares in household expenses. **Exclude** a parent who appears to visit the home based on any of the following: • The parent does not share in household expenses. • The parent has a specific time frame for his/her visits. • The parent maintains another residence. **NOTE:** Thoroughly document the case record to substantiate the inclusion or exclusion of the parent.
Parent(s) lives in the home with the child(ren) and a specified relative who has legal custody of the child(ren). Parental rights have not been terminated.	Include the parent(s) in the BG.
Pregnant minor (no existing children) lives with her parent(s) and applies for RSM or MN as a pregnant woman.	For Medicaid purposes, a pregnant minor is considered an adult. Treat the pregnant minor as a BG of two (the pregnant minor and her unborn child). Increase the BG accordingly if there are multiple fetuses. DO NOT include the pregnant minor's parent(s) in the BG.
Pregnant woman lives with the biological father of the unborn child and applies for RSM or MN as a pregnant woman.	If married, include both parents in the BG. If not married, do not include the alleged biological father unless he has existing children in the BG. **NOTE:** Budget any money he gives the pregnant woman as a contribution.
The biological father of an existing child(ren) lives in the home and there is also a legal father for the child.	Exclude the biological father from the BG and/or AU unless he signs an Affidavit of Paternity, or paternity is established through judicial proceedings or CSE. Refer to Section 2640, Paternity.

CHART 2620.1 (CONT.) – DETERMINING THE COMPOSITON OF A NON-LIM AU AND/OR BG	
SITUATION	**TREATMENT**
Specified relative other than a parent functions as grantee-relative because there is no parent in the home.	Consider including the specified relative in the BG and/or AU if s/he is within the proper degree of relationship. Refer to Section 2661, Responsibility Budgeting.
Specified relative other than a parent functions as grantee relative because the parent in the home receives SSI.	Consider including the specified relative in the BG and/or AU.
Stepparent lives in the home.	Exclude the stepparent from the AU and BG unless s/he has a child(ren) of his/her own in the BG. Refer to Section 2661, Responsibility Budgeting, unless the COA is RSM.
RSM only: 18 year old requests Medicaid under RSM.	Include the parent(s) of the 18-year-old in the BG if living in the same home. **NOTE:** The 18-year-old is considered a child for Medicaid purposes in RSM.

VERIFICATION	Accept the A/R's statement to determine the AU and BG composition unless the information provided conflicts with other information available to the agency or is otherwise questionable. A conflicting or questionable situation must be verified and documented.
DOCUMENTATION	Document the following for every individual in the home: • name and his/her relationship to the AU members • reason the individual is included or not included in the AU and/or BG.

2640 - PATERNITY

POLICY STATEMENT	The paternity of a dependent child included in a Family Medicaid AU must be established in order to determine relationship, to determine financial responsibility, to determine whether child support is being received from a non-custodial parent and to appropriately make Child Support Enforcement (CSE) referrals.
BASIC CONSIDERATIONS	Paternity is established for each child at application and when a child is added to an AU. Paternity is reestablished if a change occurs as a result of one of the following: • the mother names someone else as the father • CSE determines the man who is named as the father is not the biological father • a judicial determination alters paternity, e.g., adoption.

The following chart lists situations and the procedures to follow to establish paternity.

CHART 2640.1 - ESTABLISHING PATERNITY	
SITUATION	**TREATMENT**
Mother is unmarried at the time of the child's birth.	Accept the person she names to be the child's father.
Mother is married at the time of the child's birth.	The spouse is the legal father.
Mother is married at the time of the child's birth and states a man other than her husband is the biological father.	The husband is the legal father unless one of the following occurs: • the reputed father legitimates the child OR • the child's paternity is determined by a judicial proceeding OR • the reputed father, living in the home with the child, signs Form 185, Affidavit of Paternity OR • an affidavit of paternity is returned by CSE.
Mother is unavailable, e.g., deceased or whereabouts unknown, and an application is filed by a non-parent.	Establish paternity by one of the following: • the child's birth certificate • the reputed father's written statement acknowledging paternity • a document showing that the reputed parent has legitimated the child • written evidence that paternity has been proven in a judicial proceeding • the subsequent marriage of the reputed father to the mother and his acknowledgement that he is the father of the child • prior case record documentation of the mother's statement of paternity • SSA records showing that the child receives benefits from the reputed father's account • records of an employer showing that the child is a dependent of the reputed father for tax or insurance purposes • court records showing that the mother has, under oath, asserted the father's identity. **NOTE:** This would not apply when the court has determined the man not to be the father.

CHART 2640.1 - ESTABLISHING PATERNITY (CONT.)	
SITUATION	**TREATMENT**
CSE provides paternity test results that show the alleged father is not the father of the child AND the mother insists there is no other man who could be the father AND there is no other evidence to the contrary.	Notify CSE that a penalty will not be imposed.
CSE provides paternity test results that show the alleged father is not the father of the child AND the mother refuses to name another man as the father AND there is supporting evidence to the contrary.	Penalize the Medicaid AU member who failed to cooperate. Refer to Section 2657, Penalized Individuals.

MEDICAID MANUAL TABLE OF CONTENTS		
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2650 – FAMILY MEDICAID BUDGETING OVERVIEW

POLICY STATEMENT	All Family Medicaid Assistance Units (AUs) or Budget Groups (BGs) must have income considered in determining financial eligibility through the budgeting process.
BASIC CONSIDERATIONS	In Low Income Medicaid (LIM), AU and BG are synonymous terms, referring to those individuals both whose income and expenses are considered in determining eligibility and who receive Medicaid assistance. Non-AU member refers to those whose incomes are considered in responsibility budgeting (deeming/allocating). Non-AU members include the following: • an ineligible parent • a stepparent in which there is no mutual child included in the AU • a minor caretaker's parent • a married minor's spouse • a non-parent caretaker's spouse In Right from the Start Medicaid (RSM), BG refers to those whose income and expenses are considered in determining eligibility. AU refers to those who receive Medicaid assistance. The budgeting process includes the following: • the prospective budgeting method used to determine the AU's or BG's monthly income and expenses • the allowable deductions based on certain monthly expenses • the budgeting procedure used to calculate eligibility using monthly income and expenses.
Prospective Budgeting	Prospective budgeting uses a best estimate of income and expenses based on representative amounts to determine the AU's eligibility. The prospective income and expenses are either estimated using a conversion factor or actual income and expenses are used, depending on the case situation. Prospective income and expenses are used to budget ongoing eligibility.

BASIC CONSIDERATIONS (cont.)

Actual Budgeting

Actual income and expenses are used to budget prior months eligibility and, if available, used to budget intervening months. A/R statement of actual income and expenses may be accepted, unless questionable. Refer to Section 2053, Retroactive Medicaid.

Deductions

Certain deductions are allowed when determining the AU's eligibility. Family Medicaid Classes of Assistance (COAs) allow deductions to both earned and unearned income as follows:

- the first $50 of child support received each month
- earned income deductions as follows:
  - $90 standard work expense deduction
  - $30
  - 1/3 of the remaining earned income
  - dependent care expenses.

Family Medicaid Income Limits

Family Medicaid requires that the AU/BG have income within the following limits:

- LIM and COAs based on LIM:
  - GIC: the gross countable income of the AU must be less than or equal to the Gross Income Ceiling (GIC) for the AU size.
  - SON: the net income of the AU must be less than the Standard of Need (SON) for the AU size.

BASIC CONSIDERATIONS

Family Medicaid Income Limits (cont.)

- RSM income limits are based on percentages of the federal poverty level (FPL) as follows:
  - 235% of the FPL for pregnant women and infants born to Medicaid-eligible mothers

    NOTE: Infants born to Medicaid-eligible mothers are considered to have met the Newborn Medicaid income limit, regardless of the budget group's income at the time of delivery.
  - 185% of the FPL for infants, birth through the month the child reaches age one for children who are ineligible for Newborn Medicaid
  - 133% of the FPL for children age one through the month in which the child turns six
  - 100% of the FPL for children age six through the month in which the child turns age 19.
- Family Medicaid Medically Needy Income Limits (FM-MNIL) are based on a percentage of the SON.

The appropriate income limit for a specific COA is used in the following budgeting situations:

- to determine the AU's eligibility based on net income
- to determine in a COA based on LIM if an applicant BG with an employed individual is eligible for the $30 + 1/3 deduction
- to determine if the $30 + 1/3 deduction is necessary for an employed individual to meet the SON for a COA based on LIM
- to determine the financial responsibility or financial need of an individual who is not eligible to be included in the BG.

BASIC CONSIDERATIONS (cont.)

Earnings of a Dependent Child

The earnings of a dependent child are excluded in all Family Medicaid COAs, whether or not the child is a student.

EXCEPTION: The exclusion of earned income does not apply to the earnings of a minor applying as the caretaker and to the earnings of a minor applying as a RSM PgW.

PROCEDURES

Use the following rounding procedures when calculating budgets:

Calculate gross monthly income leaving all amounts in dollars and cents. Drop any digits past the hundredth position (second digit to the right of the decimal).

Calculate net monthly income as follows:

- allow all applicable deductions
- leave amounts remaining in dollars and cents after each deduction
- round the net monthly income to the nearest dollar. Round up if 50 cents or more. Round down if less than 50 cents.

Documentation

Document the following for all budgets:

- the amount of all gross income and expenses used in the budget, including the dates income is received and expenses are incurred and the source of verification
- the gross amounts used to calculate the representative income/ expenses
- the reason(s) any non-representative amount(s) are not used in calculations.

2653-PROSPECTIVE BUDGETING (FAMILY MEDICAID)

POLICY STATEMENT

Prospective budgeting uses a representative amount of income received and dependent care expenses incurred to determine the Family Medicaid Assistance Unit's (AU's) or Budget Group's (BG's) eligibility and benefit amount.

BASIC CONSIDERATIONS

Representative income is the amount that best represents what the AU or BG will receive on an ongoing basis.

Representative dependent care expenses are the amounts that best represent what the AU or BG will incur on an ongoing basis.

Representative income and dependent care expenses are used to determine monthly income and dependent care deductions.

Representative Income and Expenses

When the amount of the income or dependent care expense is stable (i.e., does not change from one period to the next), the stable amount is the representative amount.

When income or dependent care expenses vary, representative income and dependent care expenses are calculated as follows:

- the representative income or expense is based on available information and/or verification from the AU
- the representative income or expense may be an average of the last month's income or expense, or it may be for a specific period determined to be the most representative of the situation. In certain instances, more or less than one month income or expense is used if one month income is not representative
- periods with little or no income received or expenses incurred are disregarded when determining representative amounts unless they are determined to be representative.

Monthly income and dependent care expenses are determined by multiplying the representative amounts by the following conversion factors:

- weekly: 4.3333
- bi-weekly: 2.1666
- semi-monthly: 2
- monthly: 1

BASIC CONSIDERATIONS

Representative Income and Expenses (cont.)

Representative income and dependent care expenses are calculated at the following times:

- at the initial eligibility determination
- at periodic reviews
- when a change of income or dependent care expenses occurs

Verification

The A/R's statement of the amount of income and dependent care expenses may be accepted as the best estimate of future amounts unless the information provided conflicts with information known to the agency or is otherwise questionable. Questionable information must be verified and documented.

PROCEDURES

Follow the steps below to determine the AU's representative monthly income and dependent care expenses:

Step 1

Determine the following:

- the source and type of income or dependent care expense
- the amount of income or dependent care expense and the frequency with which the income is received or the expense is incurred

Accept the A/R's statement of income or dependent care expenses unless questionable. If questionable, request appropriate verification and document the case record.

Step 2

Calculate the representative income and/or dependent care expense.

Step 3

Convert the representative amount from Step 2 to determine the AU's monthly gross income or dependent care expense.

Document the following:

- the type and source of income and/or dependent care expenses
- verification source (document *A/R statement acceptable* if applicable)
- the frequency and amount of income and/or dependent care expenses used in determining the representative amount(s)
- the reason for determining that income and/or expenses are not representative, if applicable
- calculation of the representative amount of income and/or dependent care expenses, including conversion calculation.

Use the following chart to calculate monthly income.

CHART 2653.1 – HOW TO DETERMINE MONTHLY INCOME/EXPENSES	
IF	**THEN**
the income is either stable or fluctuating and is received more often than monthly OR the expenses are either stable or fluctuating and incurred more often than monthly	determine a representative amount of income received and/or expenses incurred by computing past, present and/or anticipated income and/or expense amounts that represent regular payments received and/or expenses incurred. Convert to a monthly amount by using the appropriate conversion factor. Document the case record. Explain what income and expenses were used, and why.
the income is received monthly or less often than monthly OR the expenses are incurred monthly or less often than monthly	do not automatically convert the income or expense. Determine the best estimate based on the following criteria: • If stable, budget the actual income received or expense incurred in the month preceding the application or review month. • If fluctuating, average the income received or expense incurred in the months immediately preceding the application or review month. • In some instances, use more or less than two months of income and/or expenses if the income received or expense incurred in the two months immediately preceding the application or review month is not representative of the ongoing situation. • Convert to a monthly amount when income received or expenses incurred by an AU is intended to cover a specified period of time. To obtain a monthly amount, divide the total income to be received or the total expenses to be incurred during the life of the contract or agreement by the number of months over which the contract or agreement extends. Document the case record. Explain what income and/or expenses were used, and why.

CHART 2653.1 (CONT.) - HOW TO DETERMINE MONTHLY INCOME/EXPENSES	
IF	**THEN**
the AU will receive income or will incur expenses, or has received income or has incurred expenses, with no change in the rate at which income has been/will be received or at which expenses have been/will be incurred	determine the representative income. Convert to a monthly amount using the appropriate conversion factors.
the AU will receive income or will incur expenses, or has received income or has incurred expenses, and the rate at which income will be received or at which expenses will be incurred has changed	do not convert. Use the actual and/or representative income/expenses. Use the actual income/expenses for dates that have already occurred AND representative income/expenses for future dates in the month.
the AU will receive less than a full month's income, will incur less than a full month's expense, has received less than a full month's income or incurred less than a full month's expenses because of new, interrupted, or terminated income and/or expenses	do not convert. Use the actual and/or representative income/ expense. Use the actual income/expense for dates that have already occurred AND the representative income/expense for future dates in that month.

If an A/R is receiving income or incurring expenses from more than one source, each source is treated separately in determining if income/expense is converted to a monthly amount.

A full month's income, if earned, is defined as receipt of or expected receipt of income at each regular pay date during a calendar month.

A full month's income, if unearned, is defined as receipt of or expected receipt of income intended to cover an entire calendar month.

A full month's expense is defined as an expense intended to cover an entire calendar month.

2655 – FAMILY MEDICAID DEDUCTIONS

POLICY STATEMENT	Deductions are applied to the BG's income to determine financial eligibility for Family Medicaid Classes of Assistance (COA).
BASIC CONSIDERATIONS	All Family Medicaid deductions are applied whether income is reported timely or untimely. There is no penalty or loss of deductions for untimely reporting.
$50 Child Support Deduction	A $50 deduction is applied to any child support income received by the Assistance Unit (AU), whether received through Child Support Enforcement (CSE) or directly from the non- custodial parent. The deduction is applied in all Family Medicaid COAs according to the following criteria: • prior to the Gross Income Ceiling (GIC) test for LIM and COAs based on LIM • to a Right from the Start Medicaid (RSM) or Family Medicaid Medically Needy (FM-MN) BG's total child support income **NOTE:** Child support and alimony payments made by a BG member cannot be deducted in determining the net countable income of the BG.
Earned Income Deductions	Earned income deductions are applied to the earned income of each employed BG member who is eligible for the deductions. Potential earned income deductions include the following and are deducted from the gross countable income in the order listed: • $90 standard work expense for each employed individual • $30 deduction for each employed individual • 1/3 of the remaining earned income for each employed individual • dependent care expenses for each child or incapacitated individual

BASIC CONSIDERATIONS

Earned Income Deductions (cont.)

Earned income deductions are applied to the earned income of the following individuals:

- BG members
- penalized individuals

Earned income deductions are applicable to the earnings of self-employed individuals. Once the countable gross income is determined by deducting the cost of doing business from gross receipts, the earned income deductions can be allowed. Refer to Section 2425, Self-Employment.

Earned income deductions do not apply to individuals whose income is deemed to an AU through the responsibility budgeting process. Refer to Section 2661, Responsibility Budgeting for allowable responsibility budgeting deductions.

PROCEDURES

$50 Child Support Deduction

Use the following procedures to apply the $50 child support (CS) deductions.

- Establish the paternity of the child before allowing the deduction. Refer to Section 2640, Paternity.

  NOTE: If paternity cannot be established, budget the money paid as a contribution. The $50 CS deduction does not apply.

- Apply the $50 CS deductions prior to the GIC test for LIM and COAs based on LIM.

- Apply only one $50 CS deduction to the total monthly amount of CS received by the BG, regardless of the number of non-custodial parents paying CS.

- Apply the $50 CS deduction to a lump sum CS arrearage payment only in the month the arrearage is received.

PROCEDURES (cont.)

$90 Standard Work Expense

Deduct the first $90 of the earnings of each employed individual in the BG, whether employed full or part time.

$30 + 1/3 Deduction - LIM

A $30 + 1/3 deduction is allowed for **each** employed BG member as follows:

- If the BG's net countable income is **less than** the appropriate SON, the AU is eligible for LIM. The $30 + 1/3 deduction is not needed, therefore not allowed.
- If the BG's net countable income is **equal to or greater than** the appropriate SON limit and the $30 + 1/3 deduction has **not** been previously exhausted, allow the $30 +1/3 deduction.
- If the BG's net countable income is **equal to or greater than** the appropriate SON limit and the $30 + 1/3 deduction has been exhausted, allow the $30 + 1/3 deduction if the individual has **not** received Medicaid under any Family Medicaid COA for 12 consecutive months since the deduction was exhausted.
- If the BG's net countable income is **equal to or greater than** the appropriate SON limit, the $30 + 1/3 deduction has been exhausted, and the individual **has** received Medicaid under Family Medicaid COA during any of the past 12 months, do **not** allow the $30 + 1/3 deduction.

If, after the $30 + 1/3 deduction the BG's net countable income is less than the appropriate SON, the AU is eligible for LIM.

If, after the $30 + 1/3 deduction the BG's net countable income is equal to or greater than the SON, deny LIM and complete a CMD.

If an individual is determined eligible for the $30 + 1/3 deduction, first deduct $30 from the individual's earnings and then deduct 1/3 of the remaining earnings.

Determine eligibility for $30 + 1/3 deduction for any employed individual added to the BG.

The $30 + 1/3 deduction is allowed for four consecutive months for each employed individual.

PROCEDURES

$30 + 1/3 Deduction - LIM (cont.)

Each employed individual can receive the $30 + 1/3 deduction therefore individuals can be in different stages of the 4 months of $30 + 1/3.

For all Family Medicaid COAs, the first month the $30 + 1/3 deduction is used, whether a retroactive, current or ongoing month, is the first month in the count of the four consecutive months.

Once the $30 + 1/3 count begins, the four-month count continues unless the individual's earned income is equal to or less than the $90 standard work deduction or there is a break in eligibility under any Family Medicaid COA. Once it begins, the four-month count continues even if there is a change in COA or the AU no longer needs the deduction to meet the appropriate SON limit.

A month of suspension does not count as a month of $30 + 1/3. Do not count the suspension month and continue the $30 + 1/3 count with the month following the month of suspension.

At the end of four consecutive months of receipt of the $30 + 1/3 deduction, the $30 only deduction is allowed for an additional 8 consecutive months. The eight month count continues regardless of the eligibility or employment status of the individual.

If an AU becomes ineligible for LIM because of the expiration of the $30 + 1/3 deduction, a CMD must be completed prior to termination of LIM. Refer to Section 2164, Work Transition Medicaid.

Once the four consecutive months of $30 + 1/3 have been applied, a LIM AU member cannot receive the deduction again until s/he has not received Medicaid for a period of 12 consecutive months.

Document all months to which the $30 + 1/3 deduction is applied.

PROCEDURES (cont.)

$30 + 1/3 Deduction-RSM and FM-MN

A $30 + 1/3 deduction is available to **each** employed BG member only if the individual was included in a LIM AU in which LIM was correctly received in any of the previous four months. If this requirement is met, allow the $30 + 1/3 deduction as follows:

For RSM:

- If the RSM BG's net countable income is **less than or equal to** the appropriate FPL limit, the AU is eligible for RSM. The $30 + 1/3 deduction is not needed, therefore not allowed.
- If the BG's net countable income is **greater than** the appropriate FPL limit and the $30 + 1/3 deduction has not been previously exhausted, allow the $30 + 1/3 deduction for four (4) consecutive months.
- If the BG's net countable income is **greater than** the appropriate FPL limit and the $30 + 1/3 deduction **has** been exhausted, do **not** allow the $30 + 1/3 deduction.
- If, after the $30 + 1/3 deduction the BG's net countable income is **equal to or less than** the appropriate FPL, the AU is eligible for RSM.
- If, after the $30 + 1/3 deduction the BG's net countable income is greater than the appropriate FPL, deny RSM and complete a CMD.

FOR FM-MN:

- If the $30 + 1/3 deduction has **not** been previously exhausted, allow the deduction.
- If the $30 + 1/3 deduction **has** been exhausted, do **not** allow the deduction.

If an individual is determined eligible for the $30 + 1/3 deduction, first deduct $30 from the individual's earnings and then deduct 1/3 of the remaining earnings.

PROCEDURES

$30 + 1/3 Deduction - RSM and FM-MN (cont.)

Determine eligibility for $30 + 1/3 deduction for any employed individual added to the BG.

For each employed individual who is eligible for the $30 + 1/3 deduction, the deduction is allowed for four consecutive months.

Each employed individual can receive the $30 + 1/3 deduction therefore individuals in the same AU can be in different stages of the 4 months of $30 + 1/3.

$30 + 1/3 count – all Family Medicaid COAs

For all Family Medicaid COAs, the first month the $30 + 1/3 deduction is used, whether retroactive, current or ongoing, is the first month in the count of the four consecutive months.

Once the $30 + 1/3 count begins, the four-month count continues unless the individual's earned income is equal to or less than the $90 standard work deduction or there is a break in eligibility. Once it begins, the four-month count continues even if there is a change in COA or the AU no longer needs the deduction to meet the appropriate FPL limit.

A month of suspension does not count as a month of $30 + 1/3. Do not count the suspended month and continue the $30 + 1/3 count with the month following the month of suspension.

At the end of four consecutive months of receipt of the $30 + 1/3 deduction, the $30 only deduction is allowed for an additional 8 consecutive months. The eight-month count continues regardless of the eligibility or employment status of the individual.

If an AU becomes ineligible for RSM because of the expiration of the $30 + 1/3 deduction, a CMD must be completed prior to the termination of RSM.

Once the four consecutive months of $30 + 1/3 have been applied, an individual cannot receive the deduction again until s/he has not received Medicaid for a period of 12 consecutive months.

NOTE: Months in which an individual is a member of the BG only and is not a member of the AU are months in which the individual did not receive Medicaid, and, therefore count toward the 12 consecutive months of non-receipt.

Document all months to which the $30 + 1/3 deduction is applied.

PROCEDURES (cont.)

$30 Deduction for Eight Additional Months

At the end of four consecutive months of receipt of the $30 + 1/3 deduction, allow the individual who received the $30 + 1/3 deduction a continuation of the $30 deduction for an additional eight months. Allow the $30 deduction as follows:

- determine and document the eight consecutive months of the $30 deduction. Once determined, these months are not subject to change
- begin the eight months of the $30 deduction the month following the fourth month of the $30 +1/3 deduction.
- continue the eight consecutive months of the $30 deduction regardless of change in COA, the eligibility status or the employment status of the individual
- a month of suspension counts as a month of the $30 deduction
- discontinue the $30 deduction after the eighth month.

Dependent Care Deductions

Allowable dependent care deductions include the expenses incurred and paid by an AU or BG member for child care or for care of an incapacitated individual in the home when the care is necessary because of the employment of an AU or BG member. Any portion of dependent care expenses that is paid for or subsidized by another agency or individual is not considered an allowable deduction.

Dependent care deductions are allowed as follows:

- for an individual under two years of age, the lesser of the actual cost or $200 monthly
- for an individual age two or older, the lesser of the actual cost or $175 monthly

NOTE: A child is considered to be age two the month following the month of the second birthday.

Verification of dependent care expenses is required only if the information provided by the A/R conflicts with information known to the agency or is otherwise questionable.

Document dependent care expenses as follows:

- the employment status which entitles the BG to a dependent care deduction
- the name of the individual(s) for whom dependent care is paid
- the frequency and date/day of week paid
- the name of the person to whom the expense is paid.

2657 – PENALIZED INDIVIDUALS

POLICY STATEMENT

An individual who fails to meet certain Family Medicaid program requirements, without Good Cause, is penalized.

BASIC CONSIDERATIONS

An individual is penalized for failure to meet, without Good Cause, any of the following Basic Eligibility Requirements:

- enumeration
- cooperation with Child Support Enforcement
- cooperation with Third Party Resources
- verification of citizenship, if questionable, or alienage

The countable income of a penalized individual is considered when determining the financial eligibility.

The income of a penalized individual receives all allowable deductions.

Do not allocate to a penalized individual.

The resources, if applicable, of a penalized individual are counted in their entirety.

A child is never penalized. If an adult fails to comply with enumeration or application for other benefits for a child, without Good Cause, the child is considered voluntarily excluded from the BG and allocation cannot be made.

Penalties are applied effective the month following the month the individual failed to meet the requirement which cause the sanction. Timely notice must be issued.

LIM

If the individual for whom this requirement is not met, without Good Cause, is a child or non-parent relative, exclude the individual and his/her income and resources from the budgeting process.

If the individual for whom this requirement is not met, without Good Cause, is a parent, the parent is penalized. Include the income and resources of the penalized parent in the budget. Include the following individuals in the LIM AU:

- the dependent child(ren), including any minor siblings, half-siblings and married minor siblings living in the home
- other eligible adult, if applicable
- any other eligible child(ren).

BASIC CONSIDERATIONS (cont.)

RSM and FM-MN

In RSM and FM-MN, a penalized individual is an adult who fails to comply with one of the following Basic Eligibility Criteria, without Good Cause:

- failure to cooperate with CSE

  EXCEPTION: A RSM Pregnant Woman is not required to cooperation with CSE for the unborn or any existing child.

- failure to cooperate with his/her own enumeration requirement
- failure to cooperate with TPR requirements
- failure to cooperate with alienage verification.

The penalized adult remains in the BG, but is not included in the AU.

LIM Budgeting Procedures for a Penalized Individual

Refer to Penalized Individual Budgeting in this Section.

For each penalized individual, determine the amount of income to count in the budgeting process.

Step 1

Follow the budgeting steps below to budget a LIM-penalized individual:

Step 2

Determine all countable earned income of the penalized individual.

Allow all appropriate earned income deductions:

- $90 standard work deduction
- $30 earned income deduction, if allowable
- 1/3 of the remaining earned income, if allowable
- Dependent care expenses.

Step 3

Add countable unearned income of the penalized adult and allow the $50 child support deduction if appropriate.

Step 4

Do not include the penalized individual when selecting the appropriate income limit for the AU.

BASIC CONSIDERATIONS (cont.)

RSM and FM-MN Budgeting Procedures for a Penalized Individual

For each penalized individual, determine the amount of income to count in the budgeting process.

Follow the steps below to budget a RSM or FM-MN penalized individual:

Step 1 Determine all countable earned income of the penalized individual.

Step 2 Allow all appropriate earned income deductions.

- $90 standard work deduction
- $30 earned income deduction, if allowable
- 1/3 of the remaining earned income, if allowable
- Dependent care expenses

Step 3 Add countable unearned income of the penalized adult and allow the $50 child support deduction, if appropriate.

Step 4 Include the penalized individual when selecting the appropriate income (and resource, for FM-MN) limit for the BG. Do not include the penalized individual in the AU.

Use the chart below to determine whom to penalize for failure to comply with certain eligibility requirements.

CHART 2657.1 - PENALITIES		
IF A PENALTY IS IMPOSED FOR:	**THEN APPLY THE PENALTY TO:**	
	LIM	**RSM AND FM-MN**
failure to comply with enumeration requirements	the non-enumerated individual(s)	an adult. Include the penalized adult in the BG but not in the AU. a child. Exclude the child from the BG.
failure or refusal to verify or declare citizenship/alienage status	the individual whose status is not verified.	the individual whose status is not verified. Include the penalized individual in the BG but not in the AU.
failure to cooperate with CSE.	the adult.	the adult. Include the penalized adult in the BG but not in the AU.
failure to cooperate with TPR requirements.	the adult.	the adult. Include the penalized adult in the BG but not in the AU.

2659 – CONTRACT EMPLOYEES

POLICY STATEMENT

Income received from contractual employment is averaged over a 12-month period if the income is not received on an hourly or piecemeal basis.

BASIC CONSIDERATIONS

Contractual employment is defined as working for a period of time less than a year.

Contract employees include truckers, certain school employees and others who contract to work on a renewable annual basis.

The contract renewal process may involve one of the following:

- signing a new contract each year
- automatic renewal of a contract
- implied renewal precluding the use of a written contract

Contract employees are considered compensated for an entire year, even during predetermined non-work periods such as summer breaks or vacations.

Income received by contract employees is considered compensation for a full year, regardless of the frequency of pay stipulated in the terms of the contract.

PROCEDURES

Follow the steps below to determine the eligibility of a contract employee:

Step 1 Determine that the individual is a contract employee.

Step 2 Determine the frequency of pay to calculate the monthly gross income.

Step 3 Multiply the monthly gross income by the number of times received to determine the annual gross income.

Step 4 Divide the annual gross income by twelve to determine the average monthly gross income.

PROCEDURES (cont.)

Step 5 Add the contract income to all other monthly income to determine the total gross monthly income.

Step 6 Apply income deductions appropriate to the COA under which eligibility is being determined.

EXCEPTIONS: Do not apply the above budgeting procedures in the following situations:

- when payments are not made as specified in the contract
- a labor dispute interrupts the flow of earnings as specified in the contract.

2661 – RESPONSIBILITY BUDGETING (FAMILY MEDICAID)

POLICY STATEMENT

Responsibility budgeting is used to determine the financial **responsibility** of an individual(s) who is ineligible to be included in the Family Medicaid AU (deemor) or to determine the financial **need** (allocation) of an individual(s) who is ineligible to be included in the AU.

BASIC CONSIDERATIONS

A responsibility budget is completed to determine if a deemor has excess income available to be deemed in the following situations:

- the amount of income to deem from an ineligible parent to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a non-AU stepparent to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a minor caretaker's parent(s) to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a non-parent caretaker's spouse to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a married minor's spouse, when living with parents, to a Family Medicaid AU
- the amount of income to deem from a married minor's spouse, not living with parents, to a Family Medicaid AU.

A responsibility budget is completed to determine if income may be allocated from an AU member to a non-AU member in the following situations:

- the amount of income to allocate from an adult in a LIM AU to his/her ineligible spouse
- the amount of income to allocate from an adult in a LIM AU to his/her ineligible child
- the amount of income to allocate from an adult in a Family Medicaid BG (other than LIM) to his/her ineligible spouse

Deductions

Allowable deductions for responsibility budgeting include the following:

- $90 Standard Work Expense
- For LIM and LIM-related COAs, the Standard of Need (SON) for the number of non-AU dependents living in the home who are or could be claimed as federal tax dependents of the ineligible adult.

BASIC CONSIDERATIONS

Deductions (cont.)

- For RSM, the FPL based on:
  - the number of non-AU dependents living in the home (including the ineligible adult) who are or could be claimed as federal tax dependents of the ineligible adult

    and

  - the age(s) of the children for whom Medicaid is requested
- For FM-MN, the appropriate FM-MNIL for the number of dependents living in the home who are or could be claimed as federal tax dependents of the ineligible adult
  - actual amounts paid to individuals outside the home who are or can be claimed as federal tax dependents
  - actual amount of alimony and/or child support paid to individuals living outside the home.

PROCEDURES

Responsibility Budget

Use only the income of the ineligible adult when completing a responsibility budget. Ineligible adults include the following:

- an ineligible parent
- a non-AU stepparent
- a minor caretaker's parent(s)
- a non-parent caretaker's spouse
- a married minor's spouse

Do not include income received by a dependent child of the ineligible adult.

Follow the steps below to complete a responsibility budget:

Step 1 Determine the gross monthly earned income of the ineligible adult.

Step 2 Deduct the first $90 from the monthly gross earned income of the ineligible adult.

PROCEDURES

Responsibility Budget (cont.)

Step 3 Add countable unearned income of the penalized adult and allow the $50 child support deduction, if appropriate.

Step 4 Determine the number of individuals living in the home with the ineligible adult who are or could be claimed as federal tax dependents of the ineligible adult. Include the ineligible adult.

NOTE: Include a SSI adult or child, disregarding his/her income. Exclude penalized individuals.

Step 5 Subtract the SON, FPL or MNIL for the number of individuals determined in Step 4 from the income calculated in Step 3.

Step 6 Subtract from the income remaining after Step 5 any amounts paid by the ineligible adult to individuals outside the home who are or could be claimed as federal tax dependents.

Step 7 Subtract from the income remaining after Step 6 any alimony and/or child support paid by the ineligible adult to individuals not living in the home.

NOTE: Do **not** include child support or alimony already subtracted in Step 6.

Step 8 If a surplus exists, deem as follows:

- from an ineligible parent to a LIM, LIM-related or FM-MN AU deem the total excess income.
- from a non-AU stepparent to a LIM, LIM-related or FM-MN AU deem excess income up to the SON for one.
- from a minor caretaker's parent to a LIM, LIM-related or FM-MN AU deem the excess income up to the SON for one.
- from a non-parent caretaker's spouse to a LIM, LIM-related or FM-MN AU deem up to the SON for one
- from a married minor's spouse to a LIM, LIM-related or FM-MN AU deem up to the SON for one
- from a married minor's spouse to a RSM BG deem the total excess income.

If a deficit exists, there is no income to be deemed to the AU or BG from the ineligible adult. Consider allocation. Refer to Allocation in this section.

PROCEDURES (cont.)

Ineligible Parent (Deeming)

An ineligible parent is a parent who cannot be included in a Family Medicaid AU (excluding RSM) with his/her dependent children for one of the following reasons:

- a parent who does not meet the citizenship/alienage requirement
- a parent who is unable to verify his/her citizenship/alienage status.

NOTE: This list is all-inclusive.

The amount of income of an ineligible parent to consider in determining eligibility for the AU is calculated by completing a responsibility budget.

Include the following individuals in the AU:

- the dependent child(ren), including any minor siblings, half-siblings and married minor siblings residing in the home
- other eligible adult(s), if applicable. Do **not** include the ineligible parent
- other eligible children.

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from an ineligible parent to the Family Medicaid AU (excluding RSM). Refer to Responsibility Budgeting Procedures in this section.

Stepparent (Deeming)

Stepparent budgeting applies when the dependent child lives in the home with a biological parent and/or the biological parent's spouse by a subsequent marriage.

The amount of income of a non-AU stepparent to consider in determining eligibility for a Family Medicaid AU (excluding RSM) is calculated by completing a responsibility budget.

PROCEDURES (cont.)

Stepparent (Deeming) (cont.)

If a child(ren) lives with a stepparent and the biological parent is not in the home or if the biological parent in the home receives SSI, the stepparent may choose one of the following options:

- elect to be excluded and have his/her income deemed through the responsibility budgeting process

OR

- elect to be included as a caretaker relative and have his/her income and resources budgeted in their entirety.

Include the following individuals in the AU when there is a stepparent and a biological parent in the home:

- dependent child(ren), including any minor siblings, half-siblings and married minor siblings residing in the home.

  EXCEPTION: Do **not** include a half-sibling who is a mutual child of the stepparent and biological parent.

- the biological parent

  EXCEPTION: Do **not** include a SSI recipient.

- other eligible adult (other than the stepparent), if applicable
- other eligible child(ren)

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from a non-AU stepparent to the Family Medicaid AU (excluding RSM). Refer to Responsibility Budgeting Procedures in this section.

PROCEDURES (cont.)

Minor Caretaker (Deeming)

Minor caretaker budgeting applies when a child is under age 18, has a child and lives in the home with his/her parents.

A minor parent, whether married, divorced or widowed, who lives with his/her parent(s) is considered a dependent child and remains the financial responsibility of his/her parent(s).

NOTE: Do not consider the income of a stepparent.

A minor parent living with her/his parents may apply for LIM (as minor caretaker) and his/her child unless the minor's parent(s) receive LIM for the siblings or half-siblings of the minor parent.

If the minor parent's siblings are receiving LIM, the minor parent must be included in the same LIM AU in order to be LIM-eligible. The minor parent's child may be included in the LIM AU also, but cannot receive a separate LIM AU. This child, however, may receive in a separate RSM AU. If the minor's child receives RSM, the income of the minor's parent(s) is not considered in the RSM budget.

If the minor parent is married and the spouse lives in the home, only the minor parent is potentially eligible to receive LIM in an AU with his/her siblings. Income from the spouse of the minor parent is deemed to this AU. The spouse of the minor parent, if under age 19, and the child of the minor parent may be considered for RSM.

Include the following in a minor caretaker's LIM AU:

- the minor parent, as the caretaker
- the dependent child(ren) of the minor parent
- the spouse of the minor caretaker

Exclude the parent and siblings of the minor parent from this AU.

Deem the income of the minor's parent(s) to the LIM AU **only** when a minor parent applies as a caretaker **and** is included in the LIM AU.

EXCEPTION: Do **not** deem to the LIM AU if the minor parent is receiving SSI, is penalized or is ineligible to be included in the AU for any other reason.

Complete a responsibility budget to determine the amount of income that must be deemed, if any, the from minor caretaker's parent(s) to the Family Medicaid AU (excluding RSM). Refer to Responsibility Budgeting in this section.

PROCEDURES (cont.)

Spouse of a Non-Parent Caretaker (Deeming)

Spouse of a non-parent caretaker budgeting applies when a married non-parent is eligible to, and elects to be included in the Family Medicaid AU (excluding RSM). Refer to Section 2245, Living with a Specified Relative.

Include the following in a Family Medicaid AU (excluding RSM) when a married non-parent caretaker elects to be included in the AU:

- the children for whom Medicaid is requested
- the non-parent as the grantee relative, if determined eligible to be included by relationship and who chooses to be included
- other eligible child(ren) of the grantee relative, if requested.

The child(ren) of the non-parent caretaker does not have to be included in the AU. This child(ren), however, cannot be included in any other AU in which the non-parent caretaker is included.

If the non-parent caretaker requests a separate eligibility determination for his/her child(ren), the non-parent caretaker must apply for his/her children separately and be included **only** in the BG with his/her children.

If the non-parent caretaker does not elect to be included in the Family Medicaid AU (excluding RSM) and requests a separate eligibility determination for his/her child(ren), the non-parent caretaker **is** eligible to be included in the AU with his/her children.

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from the spouse of a non-parent caretaker to the Family Medicaid AU (**excluding** RSM). Refer to Responsibility Budgeting in this section.

PROCEDURES (cont.)

Spouse of a Married Minor Living with Parents (Deeming)

Spouse of a Married Minor - Living with Parents budgeting applies when a married minor lives in the home with his/her parent(s) and spouse.

A married minor who lives with his/her parents and his/her spouse is considered a dependent child and remains the financial responsibility of the parent(s).

EXCEPTION: For RSM, the minor can be budgeted as an adult if she is pregnant. If the minor has an existing child, he/she can also be budgeted as a minor parent/caretaker. Neither of these situations requires deeming from the married minor's parents.

A married minor who lives with his/her parents and his/her spouse is also the financial responsibility of the spouse.

This policy continues to apply for an 18 year old who is eligible for RSM.

Include the following in the Family Medicaid AU for a married minor living with his/her parents and spouse:

- The married minor
- The parent(s) of the married minor
- Siblings and/or half-siblings of the married minor, if applicable.

Include the following in the RSM BG for a pregnant married minor living with her parents and spouse:

- The pregnant married minor
- The married minor's spouse
- The unborn child(ren)

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from a married minor's spouse to the Family Medicaid AU (**including** RSM). Refer to Responsibility Budgeting Procedures in this section.

PROCEDURES (cont.)

Spouse of a Married Minor - Not Living with Parents (Deeming)

Spouse of a Married Minor - Not Living with Parents budgeting applies when a married minor lives with his/her spouse and there are no parents in the home.

If the married minor applies for RSM-Child for him/herself, complete a responsibility budget to determine the amount of income that must be deemed, if any, from the minor's spouse, regardless of the age of the minor's spouse.

If both the married minor and his/her spouse apply for RSM-Child, eligibility is determined separately. If responsibility budgeting results in a deficit for each minor, each is RSM-Child eligible and deeming does not apply.

Refer to Responsibility Budgeting Procedures in this section.

If the married minor applies for RSM PgW, a responsibility budget is not necessary as the spouse and his income is included in the RSM-PgW BG.

If the married minor and his/her spouse apply for RSM for their child(ren), a responsibility budget is not necessary as both the married minor and the spouse are included in the RSM-Child BG.

Ineligible Spouse or Ineligible Child (Allocation - LIM)

Income may be allocated from a LIM AU member to his/her ineligible spouse and/or ineligible child.

Income is allocated to the ineligible spouse and/or child when the spouse or child is not eligible to be included in the LIM AU and when the spouse or child are any of the following:

- the spouse of a married minor
- a stepparent
- the spouse of a non-parent caretaker
- an ineligible alien or an individual for whom citizenship/legal alien status cannot be verified (spouse or child).

PROCEDURES

Ineligible Spouse or Ineligible Child (Allocation – LIM) (cont.)

Income is **not** allocated when the spouse or child is one of the following:

- penalized for one of the following reasons:
  - cooperation with CSE
  - enumeration
  - cooperation with TPR requirements
- excluded for failure to comply with application for other benefits
- receives SSI
- a child ineligible because of age
- a child for whom relationship or living arrangements is not established
- a child who is eligible to be included in the AU but was voluntarily excluded
- a child for whom the LIM-eligible adult is a relative other than a parent.

Allocation to an ineligible spouse is calculated using only the income of the spouse in the LIM AU.

Allocation to an ineligible child(ren) is calculated using only the income of the parent in the LIM AU.

NOTE: Income received for or by a child in a LIM AU may not be considered in determining the amount to allocate to an ineligible individual.

Complete a responsibility budget to determine if income may be allocated to an ineligible spouse. It is not necessary to complete a responsibility budget if allocation is considered for a child(ren) only, as the child's income is not considered when completing a responsibility budget.

PROCEDURES

Ineligible Spouse or Ineligible Child (Allocation - LIM) (cont.)

Follow the steps below to determine the amount of income, if any, to allocate to the ineligible spouse and/or child.

Step 1 If the ineligible spouse has income, complete a responsibility budget based on his income, using the appropriate SON.

- If a surplus exists, deem as indicated in the responsibility budget

  AND

  do **not** allocate to the ineligible spouse from the LIM AU. Proceed to Step 3 and allocate for any ineligible child(ren) only.

- If a deficit exists, do not deem any income from the ineligible spouse to the LIM AU. Proceed to Step 2.

Step 2 If the ineligible spouse has no income **or** if a deficit exists, allocate to the ineligible child and/or child from the LIM caretaker.

Step 3 Determine the Standard of Need (SON) for the number of ineligible individuals for whom allocation can be made.

Step 4 Determine the amount of income to allocate from the LIM caretaker to the ineligible individual(s) based on the following:

- If the only income in the LIM AU belongs to the parent, allocate up to the SON for the number of ineligible individuals. Do not exceed the parent's net income.

- If the income in the LIM AU belongs to the parents **and** others, allocate up to the SON for the number of ineligible individuals. Do not exceed the **parent's** net income.

Step 5 Subtract the allocated amount from the BG's income and continue with the eligibility determination.

PROCEDURES (cont.)

Ineligible Spouse (Allocation: other than LIM)

Income may be allocated from a Family Medicaid (other than LIM) BG to his/her ineligible spouse.

Income allocated to the ineligible spouse when the spouse is not eligible to be included in the Family Medicaid (other than LIM) BG and when the spouse is one of the following:

- a stepparent, unless s/he has biological children in the BG
- the spouse of a non-parent caretaker.

The income of a child is never allocated to any individual.

Income is never allocated to a child who is not included in the BG, whether voluntarily or involuntarily excluded.

Income is not allocated to a spouse if s/he is a SSI recipient.

The amount of income that may be allocated to an ineligible spouse is determined by completing a responsibility budget using the appropriate RSM FPL or the MNIL.

Follow the steps below to determine the amount of income, if any, to allocate to the ineligible spouse.

Step 1 If the ineligible spouse has income, complete a responsibility budget based on his/her income using the appropriate RSM FPL or the MNIL.

- If the ineligible spouse has income, complete a responsibility budget based on the FPL or MNIL for one. Do not deem any of the surplus to a RSM BG

  AND

  do **not** allocate to the ineligible spouse from the RSM or FM-MN BG.

- If a deficit exists, do not deem any income from the ineligible spouse to the RSM or FM-MN BG. Proceed to Step 2.

PROCEDURES

Ineligible Spouse (Allocation: other than LIM) (cont.)

Step 2 If the ineligible spouse has no income **or** if a deficit exists, allocate to the ineligible spouse from the RSM or FM-MN BG.

For RSM, the amount of allocation is determined by the FPL for 1, based on the age(s) of the child for whom RSM is being determined. This may require multiple allocation budgets for children of different ages.

For FM-MN, the amount of allocation is determined by the MNIL for one.

Step 3 Subtract the allocated amount from the BG's income and continue with the eligibility determination.

2663 - LOW INCOME MEDICAID BUDGETING

POLICY STATEMENT

Low Income Medicaid (LIM) budgets are calculated to determine the LIM Assistance Unit's (AU) financial eligibility.

LIM budgets are also completed when determining eligibility under Family Medicaid Classes of Assistance (COAs) which use LIM income limits.

BASIC CONSIDERATIONS

The Gross Income Ceiling (GIC) and Standard of Need (SON) are used to budget all Family Medicaid COAs except RSM, TMA and FM-MN. Refer to Appendix A2, Financial Limits for Family Medicaid.

The GIC test is used to determine financial eligibility based on the AU's gross countable income.

Gross countable income is the AU's income after deducting the following:

- $50 child support deduction, if applicable
- allocated income
- any other income excluded by law (refer to Chapter 2400, Income)
- earned income of a child.

  EXCEPTION: Earned income of a pregnant minor applying for or receiving RSM PgW and earned income of a minor parent treated as an adult are not excluded.

- cost of doing business for self-employed individuals

NOTE: Gross countable income includes deemed income. Refer to Section 2661, Responsibility Budgeting.

Any income deemed to a LIM AU is **not** used in another Family Medicaid budget unless the LIM AU members are included in the other Family Medicaid BG.

Any income allocated from a LIM AU to another Family Medicaid budget is counted in the Family Medicaid budget unless the LIM AU members are included in the other Family Medicaid BG.

BASIC CONSIDERATIONS (cont.)

A SSI recipient's income and resources are **not** considered in determining Family Medicaid eligibility. Any income given to the FM AU is however budgeted as a contribution.

All countable income and resources of the AU members, including a penalized parent, are considered in determining financial eligibility.

An individual's income and resources are not considered in two separate LIM budgets simultaneously.

The Standard of Need (SON) is used to determine financial eligibility and an employed individual's need for the $30 + 1/3 deduction. Refer to Section 2655, Deductions, for procedures used in applying the $30 + 1/3 deduction.

The SON is used to determine financial eligibility based on the AU's net countable income.

The GIC test is used to determine financial eligibility based on the AU's gross countable income. Refer to Section 2655, Family Medicaid Deductions.

PROCEDURES

Determining Financial Eligibility

Follow the steps below to establish the LIM AU's financial eligibility.

Step 1 Determine the AU members. Refer to Section 2610, LIM Assistance Units.

Step 2 Identify non-AU members whose income and resources are considered in determining financial eligibility. Refer to Sections 2661, Responsibility Budgeting and 2657, Penalized Individual.

Step 3 Determine the allowable expenses and countable income and resources of those identified in Steps 1 and 2. Refer to Section 2653, Prospective Budgeting.

Step 4 Determine that the AU's total countable resources are less than or equal to the LIM resource limit and proceed to Step 5. If the AU's total countable resource exceed the LIM resource limit, complete a CMD, deny or terminate LIM and notify the AU.

Step 5 Complete a LIM budget to determine LIM financial eligibility.

PROCEDURES (cont.)

LIM Budget

Follow the steps below to complete a LIM budget.

Step 1

Complete the GIC test by comparing the gross countable income of the AU to the GIC for the AU size.

If the gross countable income is equal to or less than the GIC, proceed to Step 2.

If the gross countable income is greater than the GIC, complete a CMD, deny or terminate LIM and notify the AU.

Step 2

Complete a trial SON budget to determine if the AU's net countable income is less than the SON.

The AU's net countable income includes the following:

- gross wages less the $90 standard work deduction and dependent care expenses
- plus unearned income (including deemed income) less the $50 child support deduction, if applicable
- less allocation

If the AU's net countable income is less than the SON, skip to Step 5.

If the AU's net countable income is greater than or equal to the SON and includes earned income, proceed to Step 3.

If the AU's net countable income is greater than or equal to the SON and does not include earned income, complete a CMD, deny or terminate LIM, and notify the AU.

Step 3

Determine if an employed individual(s) is eligible to receive the $30 + 1/3 deduction. Refer to Section 2655, Deductions.

If the employed individual(s) is not eligible to receive the $30 + 1/3 deduction, complete a CMD, deny or terminate LIM and notify the AU.

If the employed individual(s) is eligible to receive the $30 + 1/3 deduction, proceed to Step 4.

PROCEDURES

LIM Budget (cont.)	
Step 4	Complete a SON budget including the $30 + 1/3 deduction. The $30 + 1/3 deduction is applied only to earned income and is applied after the $90 standard work deduction. If the AU's net countable income is less than the SON, proceed to Step 5. If the AU's net countable income is greater than or equal to the SON, complete a CMD, deny/terminate LIM and notify the AU.
Step 5	Approve LIM and notify the AU.

2665 – LIM AU MEMBER IN A NURSING HOME BUDGETING

POLICY STATEMENT	A member of a LIM AU (caretaker, second eligible adult or a child) who is temporarily in a nursing facility may remain eligible for LIM benefits.
BASIC CONSIDERATIONS	If the nursing facility care is expected to be temporary, the individual can continue to be included in the LIM AU while in the nursing facility. If the nursing facility care is expected to be permanent, the individual is not considered to be living in the home and cannot be included in the LIM AU. When a LIM individual is admitted to a nursing facility, the facility will send a completed Form DMA-6, Physician's Recommendation Concerning Skilled Nursing Home, Intermediate Care or Intermediate Care for the Mentally Retarded, to the Georgia Medical Care Foundation (GMCF) for a Level of Care (LOC) recommendation.
PROCEDURES	Refer to procedures outlined in Section 2172, LIM Individual in a Nursing Home, to determine if the AU member requires temporary or permanent nursing home care. Follow the steps below if it is determined that the LIM AU member was admitted to the nursing facility for temporary care.
Step 1	Determine LIM eligibility for all AU members, including the individual in the nursing facility as if s/he were in the home.
Step 2	Authorize the vendor payment to the nursing facility if the individual is LIM-eligible. Refer to budgeting procedures in this section.
Step 3	Notify the AU of the eligibility decision.

PROCEDURES (cont.)

Budgeting Procedures	Follow the budgeting steps below.
Step 1	Determine the number of eligible individuals to include in the AU, including the AU member in the nursing facility.
Step 2	Reduce the number of individuals in the Gross Income Ceiling (GIC) test by one and add $44 to the amount to include the needs of the AU member in the nursing facility.
Step 3	Reduce the number of individuals in the Standard of Need (SON) test by one and add $24 to include the needs of the AU member in the nursing facility.
Step 4	Follow regular LIM budgeting procedures.
Step 5	Authorize the vendor payment to the nursing facility.
Permanent Care or SSI-Eligible	If it is determined that the AU member was admitted to the nursing facility for permanent care, remove the individual from the LIM AU and determine eligibility under an ABD COA.

2667 - TRANSITIONAL MEDICAL ASSISTANCE BUDGETING

POLICY STATEMENT	Transitional Medical Assistance (TMA) Budgeting procedures are used to determine continued financial eligibility for TMA during the Additional Six Month Extension.
BASIC CONSIDERATIONS	The AU must have received TMA in each of the six months of the initial six month period and must have provided information in the 4th month of TMA eligibility to qualify for the additional six month extension. The TMA budgeting procedure is used to budget earnings and incurred child care expenses reported on the TMA Quarterly Report Form (QRF) returned to the EW in the seventh and tenth months of TMA eligibility. A/R statement is accepted for earnings reported on the fourth, seventh and tenth months QRFs, unless questionable. If the gross countable earnings of the AU are less than the TMA income limit for the AU size, the incurred child care costs do not have to be considered. **NOTE:** Refer to Section 2166, Transitional Medical Assistance, for the time frames for processing the QRF, budgeting for the first six month extension, and other policy information.
PROCEDURES	
TMA Budgeting	Follow the steps below to budget the three months of earnings and child care costs reported on the TMA Quarterly Report Form (QRF) in the 7th and 10th months.
Step 1	Determine the AU's total gross earned income for each month reported on the QRF. Do not include unearned income. Client statement is acceptable verification, unless questionable.
Step 2	Determine the total incurred child care expense for each month reported on the QRF if the gross countable earned income is greater than the TMA income limit. Client statement is acceptable verification, unless questionable.
Step 3	Budget each month individually. Subtract the child care expense from the gross earned income, if necessary.
Step 4	Add the amounts determined in Step 3 and divide by 3 to obtain the average net monthly earnings.

PROCEDURES

TMA Budgeting (cont.)

Step 5 Compare the average net monthly earnings to the TMA income limit for the AU size. Refer to Appendix A2, Financial Limits for Family Medicaid.

- If the average net monthly earnings from Step 4 are less than or equal to the TMA income limit for the AU size, continue TMA coverage.
- If the average net monthly earnings from Step 4 exceed the TMA income limit, discontinue TMA eligibility after giving adequate notice. Complete a CMD.

When the TMA Annual Adjustment Occurs

Follow the steps below when the TMA income limit changes because of the annual adjustment.

Step 1 Add the earned income for each month together, subtract allowable child care expenses and divide by three.

Step 2 Compare the average net earnings from the three month period to the average TMA income level for the three month period.

- If the average net monthly earnings are less than or equal to the average TMA income limit for the AU size, continue TMA coverage.
- If the average net monthly earnings exceed the average TMA income limit, discontinue TMA eligibility after giving adequate notice. Complete a CMD.

2669 - RSM BUDGETING

POLICY STATEMENT

Right from the Start Medicaid (RSM) budgeting procedures are used to budget all applications and periodic reviews of financial eligibility for RSM Pregnant Women (RSM-PgW) and RSM-Child.

BASIC CONSIDERATIONS

The RSM budget includes the income of all individuals in the budget group (BG).

RSM uses LIM criteria for determining types of included income and expenses for BG members.

EXCEPTION: Refer to Section 2650, Budgeting Overview for treatment of earnings of a minor.

A percentage of the FPL is used to determine RSM financial eligibility based on the BG's net countable income.

Countable income is the BG's income after deducting the following:

- $50 child support deduction, if applicable
- allocated income
- any other income excluded by law (refer to Chapter 2400, Income)
- earned income of a child

  EXCEPTION: Earned income of a pregnant minor applying for or receiving RSM PgW and earned income of a minor parent treated as an adult are not excluded.

- cost of doing business for self-employed individuals.

Countable income includes deemed income. Refer to Section 2661, Responsibility Budgeting.

Individuals having financial responsibility in RSM include the following:

- parents are financially responsible for children
- spouses are financially responsible for spouses

PROCEDURES

Follow the steps below to determine eligibility for RSM.

Step 1 Determine the gross countable income of the BG.

Step 2 Subtract from the gross countable income the following deductions in the order indicated:

- $50 child support deduction using LIM criteria
- $90 earned income deduction for each employed BG member
- $30 earned income deduction, if allowable, for each employed individual
- 1/3 of the remaining earned income, if allowable, for each employed individual
- dependent care expenses using LIM limits.

Refer to Section 2655, Family Medicaid Deductions.

Step 3 Deduct any allocated income. Refer to Section 2661, Family Medicaid Responsibility Budgeting.

Step 4 Select the appropriate RSM income limit, a percentage of the Federal Poverty Level (FPL) for the BG size using the criteria below. Refer to Appendix A2, Financial Limits for Family Medicaid.

- 235% of the FPL for pregnant women and infants born to Medicaid-eligible women
- 185% of the FPL for infants, birth through the month the child reaches age one for children who are ineligible for Newborn Medicaid.
- 133% of the FPL for children age one through the month in which the child turns age six.
- 100% of the FPL for children age six through the month in which the child turns age 19.

PROCEDURES (cont.)

Step 5 Compare the net countable income to the appropriate RSM income limit for the BG size.

- If the net countable income is less than or equal to the appropriate RSM income level, approve the AU members for RSM.

- If the net countable income exceeds the appropriate RSM income level for the BG size, the AU members are ineligible for RSM. Complete a CMD including the referral of an ineligible child to PeachCare for Kids (PFK).

NOTE: Because the RSM-Child income limits vary based on the age of the child, it is possible that a child(ren) may be eligible for RSM while another child(ren) in the same BG may be ineligible. Complete a CMD as indicated above for an ineligible child(ren) in a budget group.

2671 - FAMILY MEDICAID MEDICALLY NEEDY BUDGETING

POLICY STATEMENT	Family Medicaid Medically Needy (FM-MN) Class of Assistance (COA) budgeting procedures are used to budget applications and reviews of financial eligibility for the FM-MN COA.
BASIC CONSIDERATIONS	The FM-MN budget group includes the income of all individuals in the Budget Group (BG). FM-MN uses LIM criteria for determining the types of included income and expenses.

PROCEDURES

Determining De Facto Eligibility and One-Month Spenddown

Follow the steps below to budget for de facto eligibility or the spenddown for each one-month budget period of the six month review period in a FM-MN case:

Step 1

Determine prospective gross countable income of the budget group (BG) for each month of the six-month review period.

Step 2

Subtract from the gross countable income the following deductions in the order indicated:

- $50 child support deduction using LIM criteria
- $90 earned income deduction for each employed BG member
- $30 earned income deduction, if allowable, for each employed individual
- 1/3 of the remaining earned income, if allowable, for each employed individual
- dependent care expenses using LIM limits.

Refer to Section 2655, Family Medicaid Deductions.

Step 3

Deduct any allocated income to determine the net countable income. Refer to Section 2661, Responsibility Budgeting.

Step 4

Determine the Medically Needy Income Limit (MNIL) based on the BG size for each one-month budget period in the six-month FM-MN review period. Refer to Appendix A2, Financial Limits for Family Medicaid.

PROCEDURES

De Facto Eligibility and One-Month Spenddown (cont.)

De Facto Eligible

The AU is de facto eligible for FM-MN for each one-month budget period in which the net countable income is less than or equal to the MNIL.

Spenddown

If the net countable income exceeds the MNIL, the excess is the spenddown. The AU is Medicaid eligible when, and only if the spenddown is reduced to zero by subtracting incurred medical expenses.

Refer to Section 2196, Family Medicaid Medically Needy for information regarding incurred medical expenses and procedures for applying incurred medical expenses to the spenddown.

De Facto Eligibility and Spenddown for a Prior Month

Budget each prior month separately. Each prior month is a one-month budget period.

Follow the procedures below to determine FM-MN de facto or spenddown for a prior month.

Step 1

Determine the gross countable income received by the BG in each prior month for which assistance is requested.

Step 2

Subtract the following deductions from each month's income in the order indicated:

- $50 child support deduction using LIM criteria
- $90 earned income deduction for each employed BG member
- $30 earned income deduction, if allowable, for each employed individual
- 1/3 of the remaining earned income, if allowable, for each employed individual
- Dependent care expenses using LIM limits.

Refer to Section 2655, Family Medicaid Deductions.

PROCEDURES (cont.)

De Facto Eligibility and Spenddown for a Prior Month (cont.)

Step 3	Deduct any allocated income to determine net countable income. Refer to Section 2661, Family Medicaid Responsibility Budgeting.
Step 4	Determine the MNIL for the BG size for the prior month. Refer to Appendix A2, Financial Limits for Family Medicaid.
Step 5	Compare the MNIL determined in Step 4 to the net countable income for the prior month.
De Facto Eligible	If the net countable income is less than or equal to the MNIL, the AU is de facto eligible for FM-MN.
Spenddown	If the net countable income exceeds the MNIL, the excess is the spenddown. The AU is Medicaid eligible when, and only if the spenddown is reduced to zero by subtracting incurred medical expenses. Refer to Section 2196, Family Medicaid Medically Needy, for information regarding incurred medical expenses and procedures for applying incurred medical expenses to the spenddown.

Use the following chart to determine FM-MN budgeting procedures for special situations.

CHART 2671.1 - MEDICALLY NEEDY BUDGETING FOR SPECIAL SITUATIONS

NOTE: The "If" column assumes that all potentially eligible individuals are requesting Medicaid.

IF family consists of	THEN complete budgeting as follows:
minor parent, his/her child and his/her parent(s)	Treat both the minor parent and his/her child as dependent children and include them in his/her parent(s)' BG. Budget for FM-MN using all BG income and medical bills. Treat the minor parent as caretaker. Include only the minor parent and his/her child in the BG. If the minor caretaker is treated as a caretaker, use one of the following options to budget. **Option 1** Complete a minor caretaker responsibility budget using the minor's parent(s)' income. Meet needs in the responsibility budget using the MNIL for one (or MNIL for two if there are two parents). Deem all income remaining at the end of the responsibility budget in the minor parent's FM-MN budget. Include the medical bills of the minor, minor's child, and the parent(s) of the minor to meet spenddown. Approve only the minor's child when spenddown is met. **Option 2** Complete a minor caretaker responsibility budget using the minor's parents' income. Meet needs in the responsibility budget using the MNIL for one (or MNIL for two if there are two parents). Include in the minor parent's MN budget the amount (not to exceed the MNIL for one) from the income remaining at the end of the responsibility budget. Use only medical bills of the minor parent and her child to meet spenddown. Approve only the minor's child for Medicaid when spenddown is met.

CHART 2671.1 – MEDICALLY NEEDY BUDGETING FOR SPECIAL SITUATIONS (CONT.)

NOTE: The "If" column assumes that all potentially eligible individuals are requesting Medicaid.

IF family consists of	THEN complete budgeting as follows:
pregnant minor and her parent(s)	Treat the pregnant minor as a dependent child and include her in a BG with her parents. Budget for MN using all BG income and medical bills. OR Include only the minor parent and her unborn child in the BG. Use the following steps to budget if only the minor parent and her unborn child are included in the BG.
Step 1	Complete a minor caretaker responsibility budget using the pregnant minor's parent(s)' income. Meet the needs of the minor's parent(s) using the MNIL for one (or MNIL for two if two parents).
Step 2	Deem to the pregnant minor's MN budget the amount of income remaining at the end of the responsibility budget, not to exceed the MNIL for one.
Step 3	Add to this any countable income of the pregnant minor with appropriate deductions.
Step 4	Complete MN budgeting. • Approve if de facto eligible. • Place in spenddown status if excess exists.
Step 5	Use only medical bills of the minor parent to meet spenddown.
Step 6	Approve the pregnant minor for Medicaid when spenddown is met.

CHART 2671.1 - MEDICALLY NEEDY BUDGETING FOR SPECIAL SITUATIONS (CONT.)

NOTE: The "If" column assumes that all potentially eligible individuals are requesting Medicaid.

IF family consists of	THEN complete budgeting as follows:
pregnant minor with an existing child and her parent(s)	Treat the pregnant minor as a dependent child and include her, her child if Medicaid is requested, and her parents in the BG. Budget for FM-MN using all BG income and medical bills. OR Treat the pregnant minor parent as a caretaker. Include the pregnant minor parent, her unborn child and her existing child in the BG. Use the following steps to complete the budget.
Step 1	Complete a minor caretaker responsibility budget using the pregnant minor's parent(s) income. Meet the needs of the minor's parent(s) using the MNIL for one (or MNIL for two if there are two parents). The remainder is used in the pregnant minor's budget.
Step 2	Deem to the pregnant minor's BG up to the MNIL for one from the remainder in Step 1.
Step 3	Add to Step 2 any income of the pregnant minor and her existing children, allowing appropriate exclusions and deductions.
Step 4	Compare the total in Step 3 to the MNIL for the BG size. • If the total is less than or equals the MNIL, approve the minor's existing child(ren) as de facto eligible. • If the total exceeds the MNIL, the excess is the spenddown for the minor's existing child(ren). Medical expenses for the pregnant minor and child(ren) can be used to meet this spenddown.
Step 5	To determine the pregnant minor's eligibility, complete these calculations. • Deem to the pregnant minor the remainder of Step 1 minus Step 2. The result is the spenddown for the pregnant minor. • Apply allowable medical expenses incurred by the pregnant minor and her existing child to the spenddown. Repeat these steps for each budget period month in the six-month review period.

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2700 - CASE MANAGEMENT OVERVIEW

POLICY STATEMENT

Case Management is the process by which the DFCS eligibility worker (EW) monitors the ongoing eligibility received by the ABD and Family Medicaid recipient. Case Management begins immediately following the approval of a Medicaid application and continues as long as the Assistance Unit (AU) remains eligible for Medicaid.

BASIC CONSIDERATIONS

Case Management consists of the following components:

- Notifications
- Reviews
- Changes
- Alerts
- Continuing Medicaid Determinations (CMDs)
- Case Management Lists
- Computer Matches
- Hearings

Notification

An AU must receive proper notification of actions taken on his/her Medicaid case. Refer to Section 2701, Notification.

Reviews

An semi-annual review of eligibility is conducted to insure that the recipient continues to be eligible for Medicaid under the correct Class of Assistance (COA). AUs are required to cooperate with the periodic review of eligibility. Refer to Section 2706, ABD Reviews and 2710, Family Medicaid Reviews.

Changes

AUs are required to report all changes which may affect their eligibility. A change in resources, income or other circumstances reported by the recipient must be acted upon in a timely manner. Refer to Section 2708, ABD Medicaid Changes and 2712, Family Medicaid Changes Overview.

Alerts

The SUCCESS system generates Alerts, messages to the caseworker to take specific action on a case. Appropriate action should be taken on the Alert in a timely manner. Alerts include, but are not limited to, notification of annual review, results of IEVS/Clearinghouse matches, removing the Medicare premium from the budget, expiration of the DMA-6 or similar document and caseworker generated Alerts.

BASIC CONSIDERATIONS (cont.)

CMD

If an AU or an individual in an AU is determined ineligible at application or while receiving Medicaid, a Continuing Medicaid Determination (CMD) must be completed. The CMD process is used to explore eligibility for all other COAs before denying or terminating Medicaid. Refer to Section 2052, Continuing Medicaid Determination.

Case Management Lists

Reports produced by DFCS and DMA inform the EW of required case actions and aid in monitoring continued Medicaid eligibility for certain recipients. Refer to Section 2750, Case Management Reports Overview.

Computer Matches

Computer matches are generated by matching DFCS information with the information of other agencies, such as Georgia Department of Labor, the Social Security Administration and the Internal Revenue Service. These matches assist with verification of the recipient's income and resources and act as an aid in detecting unreported income and resources. Refer to Chapter 2000, General Program Overview for additional information regarding computer matches.

Hearings

The applicant or recipient (A/R) has the right to request a hearing on any decision made by DFCS or DMA affecting his/her Medicaid eligibility and/or patient liability/cost share. The EW has certain responsibilities in processing the request for a hearing. Refer to Appendix D, Hearings.

2701 - NOTIFICATION

POLICY STATEMENT

Written notice to the AU is required when any of the following occur:

- approval or denial of an application for benefits
- change in patient liability/cost share
- addition or deletion of an individual in an AU
- denial or termination of an individual's benefits because of a sanction, IPV disqualification or ineligibility
- termination of benefits to the AU or to an AU member.

BASIC CONSIDERATIONS

Written notifications must include the following:

- the proposed action
- the reason for the action
- period of eligibility
- notification of appeal rights and information regarding the filing of an appeal
- the availability of free legal representation, including telephone number
- the telephone number and name of a person to contact for additional information
- the specific Medicaid regulation must be cited for denials.

Written notice is program specific and is generated by the system. When system-generated notice explanation is inadequate, additional documentation on the notice is required. Generic denial reasons, such as "call your caseworker" may be used as a secondary or tertiary denial/ termination reason, but **never** as the sole reason for denial/ termination.

Written notice can be mailed to the AU or hand delivered to the AU during an interview.

Adequate notice is a written communication provided to the AU no later than the date the action is taken.

Timely notice is a written communication provided to the AU with at least a 10 day waiting period before the date the proposed action is effective.

PROCEDURES

Adequate Notice

Provide adequate notice in the following circumstances:

- mass changes in benefits initiated by the State or federal government including the following:
  - TANF, RSDI and SSI adjustments
  - financial standards and benefits levels
  - deductions
- death of all members of the AU reported through reliable information
- denial of an application
- a clear written statement from the A/R requesting termination of benefits for the entire AU
- a written request by the AU for voluntary termination
- the AU reports information in writing and ineligibility can be determined without verification
- benefits were approved for a specific time period and the AU was informed in writing of the proposed termination, or change in benefits at approval
- the AU moves out of state.

Timely Notice

Implement the proposed change effective the month following the expiration of the 10 day timely notice period.

If the AU provides information within 10 day timely notice period that alters the proposed change, stop the action and reevaluate the circumstances.

Allow the system to automatically track the 10 day timely notice period if the action is entered in the system.

Manually track the 10 day timely notice if a manual notice is sent.

The AU may request a fair hearing and continuation of benefits. Refer to Appendix D, Hearings for policy regarding continuation of benefits.

PROCEDURES (cont.)

Timely Notice (cont.)

Provide timely notice in the following circumstances:

- changes in AU circumstances causes termination of benefits
- change in patient liability/cost share
- mail returned and/or whereabouts unknown

2706 - ABD MEDICAID REVIEWS

POLICY STATEMENT

An annual review of eligibility is required for each ABD Medicaid recipient.

PROCEDURES

Complete an annual review by the end of the 12th month after initial ABD Medicaid approval on the system or the 12th month after the most recent annual review.

At application and yearly review, indicate on the MISC screen in the system if the review is to be completed as an alternate (A) or standard (S) review. On the 15th of the month preceding the review month, the system will initiate the following:

IF	THEN
A standard review is indicated,	the system schedules and mails review appointments.
An alternate review is indicated,	the system mails a packet of information on income, resources, etc., for completion and return to the EW.

Follow the steps below to complete an annual review:

Step 1 Identify which cases for review are to be standard and which are to be alternate reviews.

Step 2 Allow the system to schedule reviews. If reviews are scheduled manually, use the following guidelines:

For alternate reviews, give a 15 day deadline from the date of mailing for the A/R or PR to return documents and any required verification.

For standard reviews, give a 10 day deadline from the date of interview for the A/R or PR to return any required verification.

Step 3 Review the information for completeness upon receipt. Contact the A/R or PR immediately if documents/verifications are incomplete or information is questionable. Request additional information as needed.

Document verification of income and resources appropriately in the system when received.

PROCEDURES (cont.)

Step 4 Complete a face-to-face contact with the A/R if required by the COA.

NOTE: Face-to-face contact is not required at annual review for nursing home A/R's.

Face-to-face contact is also not required at annual review for A/R's who receive QMB/SLMB/QI-1 or QI-2 only.

Step 5 Complete appropriate updates in the system to recalculate patient liability/cost share for appropriate COAs if changes in income or IMEs are reported. Proper notification is to be sent to the A/R.

Step 6 Update appropriate information on the system and document continued eligibility.

NOTE: If the A/R is determined to be ineligible under the current COA, complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

A/R Does Not Respond

Follow the procedures below if the A/R or PR does not return the documents or verifications by the deadline:

- Telephone the A/R or PR to determine the reason for the delay. If the delay is beyond the control of the A/R, PR or the EW, the review may pend into the following month and will be an excused OSOP.
- If the A/R does not have a telephone, send a final notice giving the A/R 7 days to provide verification.
- If the A/R or PR responds and cooperates, follow Steps 1 through 5 for completing the review.
- If the A/R or PR did not have good cause for the delay or refuses to cooperate with the review process, terminate ABD Medicaid eligibility prior to the end of the review month allowing sufficient time for timely notice.

Standard of Promptness

Thoroughly document the reason for delay, termination or closure.

2708 - ABD MEDICAID CHANGES

POLICY STATEMENT	A change that occurs in the A/R's circumstances between review periods or a change in federal or state policy must be reviewed for its effect on ABD Medicaid eligibility and patient liability/cost share.
BASIC CONSIDERATIONS	Changes in an A/R's circumstances are to be reported to DFCS by the A/R or PR within 10 calendar days of the change. Action on all changes reported must be initiated by DFCS within 10 days of receipt of the report. Using appropriate documentation standards, document when the change was received and the required action completed. There are two types of ABD Medicaid changes: - financial - non-financial
Financial Changes	Financial changes are those that affect an individual's or a couple's Medicaid eligibility due to a change in income and/or resources.

Use the following chart to determine the required actions on specific financial changes.

CHART 2708.1 - FINANCIAL CHANGES	
IF the change is	**THEN complete the following actions:**
In the income of the A/R, spouse or parent, such as one of the following: • Increase • Decrease • Receipt of VA A&A • Lump sum • Income averaging	1. Verify income using the appropriate verification procedures. 2. Enter correct income into the system. 3. Review the system calculation of patient liability/cost share. 4. System will generate notice. 5. Document appropriate screens.
In the resources of the A/R, spouse or parent, such as the following: • A new resource reported or discovered	1. Reverify ownership when applicable. 2. Reverify value of all countable resources. 3. Enter new resource information into the system. 4. Review system calculation of resource eligibility. 5. Document appropriate screens.
Reconciliation of income and IME's	1. Verify actual IME's incurred and income received in the previous three month budget period. 2. Determine reconciliation amount manually, or by using RECO screen. 3. Enter appropriate information into the system to recalculate patient liability/cost share. 4. System will generate notice. Customize notice if necessary. 5. Document appropriate screens.

PROCEDURES (cont.)

Non-Financial Changes Non-financial changes are changes that do not affect eligibility but do require DFCS action to insure the continued receipt of correct benefits.

Use the following chart to determine the required action on specific non-financial changes:

CHART 2708.2 - NON-FINANCIAL CHANGES

IF the change is	THEN complete the following actions:
An address change for the A/R or PR	1. Determine if the A/R's new address is in the current county of residence, another county within the state or out-of-state. 2. Update the system with the new address. 3. Initiate transfer procedures if the address is out of county. Refer to *the client's move to another county within the state* in this chart. 4. Terminate Medicaid eligibility if the A/R moves out of state. 5. Document the system appropriately.
In the A/R's class of assistance	1. Verify that the A/R meets all criteria for the new COA. 2. Complete add a program function for the new COA OR enter appropriate information into the system for the case to trickle to the new COA. 3. Document appropriate screens.
Limited Stay Expires	1. Upon receipt of a Form DMA-6 from GMCF extending the limited stay, enter the new termination date into the system. DO NOT enter a new payment date unless there is a gap between the previous termination date and the new payment date. 2. Document appropriate screens. **NOTE:** Enter information for *ongoing and all affected previous months.*
In the A/R's level of care (LOC)	1. Upon receipt of a Form DMA-6 from GMCF approving a new LOC, enter appropriate information into the system, including new LOC, new termination date, and new payment date if a gap exists between the previous termination date and new payment date. Do not enter a new payment date if there is no gap; do not enter a new admission date. 2. Document appropriate screens. **NOTE:** Enter LOC information for *ongoing and all affected previous months.*

CHART 2708.2 - NON-FINANCIAL CHANGES (CONT.)	
IF the change is	**THEN complete the following actions:**
A request for prior months Medicaid on a previous application (not a part of a current application and as long as the prior months have not been correctly denied previously)	1. Determine appropriate COA for the prior months. 2. Register an application using previous application date as current application date. 3. Complete the Prior Medicaid Copy for the prior months on the system. 4. Verify all income and resources for the prior months using appropriate verification procedures. 5. Enter all income and resource information into the system for the appropriate months. 6. Use the system to calculate eligibility and send notice for the prior months. 7. Document appropriate screens.
The death of the A/R	1. Verify date of death. 2. Enter the date of death into the system on all appropriate screens, including DEM2 and INST, for all affected months. 3. Document appropriate screens.
The A/R's discharge from LA-D to home (LA-A or B)	1. Verify date of discharge. 2. Enter appropriate information into the system for protection of income and new address. 3. Enter appropriate discharge information into the system for ongoing and all affected months. 4. Complete a CMD.
The A/R's move from one county to another within the state	1. Contact the DFCS office in the A/R's new county of residence via telephone or e-mail to request transfer. 2. Complete all pending work on the case. 3. Change the A/R's address in the system. 4. Change the county code and local office number in the system. 5. Transfer to the receiving load number in the system. 6. Mail the physical case record to the receiving county. 7. Complete a review within 30 days of the date of receipt of the case record from the transferring county. Refer to Section 2706, ABD Reviews. **NOTE:** For nursing home cases in which the A/R enters a nursing home in the receiving county, DO NOT enter the discharge information into the system. Document the discharge information on REMA behind INST for the receiving county to complete the discharge.

2710 - FAMILY MEDICAID REVIEWS

POLICY STATEMENT	Medicaid Assistance Units (AUs) must comply with periodic reviews of continued eligibility.
BASIC CONSIDERATIONS	Family Medicaid reviews must be completed semi-annually. **EXCEPTION:** Semi-annual reviews are not required for the following Medicaid Classes of Assistance: • RSM PgW • Newborn Medicaid • TMA • 4MCS Refer to chart 2710.1, Family Medicaid Reviews to determine which COAs require reviews. At the discretion of the eligibility worker (EW), reviews may also be completed at other times because of changes reported by or affecting the AU. The review process must be completed by the last day of the month the review is due. The following points of eligibility must be reviewed, if applicable: • resources • income • dependent care expenses • application for other benefits • financial management **EXCEPTION:** Financial management is not a consideration in RSM COAs. • living arrangements • any other points of eligibility subject to change Reviews are completed by one of the following methods: • alternate review • standard review

BASIC CONSIDERATIONS (cont.)

Standard Review

A standard review is an-depth face-to-face (FTF) interview in which all points of eligibility are examined with an appropriate AU or BG member or a personal representative (PR)

A standard review is completed by the end of the sixth month following completion of an alternate review.

A standard review appointment notice must include the following:

- that a review is necessary to continue eligibility
- the consequences of failing to comply with the review
- the date, time and location of the interview
- the AU's responsibility for rescheduling a missed appointment
- the AU's responsibility to provide all required verification
- the AU's right to request a fair hearing
- the name and telephone number of the eligibility worker

An alternate review is an abbreviated review of continued eligibility in which a FTF interview is not required.

Alternate Review

An alternate review is completed by the end of the sixth month following the month in which the application is approved and by the end of the sixth month following a standard review.

Alternate reviews cannot be completed consecutively, however consecutive standard reviews are allowed.

EXCEPTION: Standard (FTF) reviews are not required for RSM.

An alternate review notice must contain the following information:

- that a review is necessary to continue eligibility
- an alternate review form (system-generated or manual)
- the date the alternate review form is due
- the consequences of failing to return the alternate review form
- the AU's responsibility to provide all required verification
- the AU's right to request a fair hearing
- the address of the office completing the review
- the name and telephone number of the EW

PROCEDURES

Standard Review Refer to Chart 2710.2, Procedures for Disposition of a Medicaid Review.

Follow the steps below to process a standard review.

Step 1 Mail to the AU an appointment notice to schedule the standard review. An appointment notice must be mailed to the AU no less than 10 days prior to the scheduled appointment.

EXCEPTION: The 10-day requirement does not apply to appointments scheduled verbally, either in person or by telephone.

The interview must be scheduled for a date that allows for sufficient processing of the review by the due date.

Step 2 Conduct a FTF interview with the appropriate AU/BG member.

Review all points of eligibility.

Step 3 Request additional information or verification, if appropriate.

Step 4 Document the information obtained during the review process.

Step 5 Complete additional forms as needed to verify points of eligibility.

- Form 297A, Rights and Responsibilities
- Form 354, Expense Statement

NOTE: Form 354 is not required for RSM.

Step 6 Complete Clearinghouse requirements.

Step 7 Upon completion of the interview, and if applicable, the receipt of any additional information or verification requested, finalize the review.

Step 8 Notify the AU of the review disposition.

PROCEDURES (cont.)

Alternate Review

Refer to Chart 2710.2, Procedures for Disposition of a Medicaid Review.

Follow the steps below to process an alternate review:

Step 1 Mail the alternate review form to the AU no less than 10 days prior to the date the completed form is due.

Step 2 Review the completed review form and all points of eligibility.

Step 3 Contact the AU if additional information or verification is needed or if the review form is incomplete. Contact may be made by telephone or by mail.

Step 4 Complete Clearinghouse requirements.

Step 5 Document the information obtained during the review process.

Step 6 Upon completion of the review and, if applicable, the receipt of any additional information or verification requested, finalize the review.

Step 7 Notify the AU of the review disposition.

Use the following chart to determine which Family Medicaid COAs require a review.

Chart 2710.1 - Family Medicaid Reviews

CLASSES OF ASSISTANCE	SPECIAL REVIEWS	SIX MONTH REVIEWS REQUIRED
LIM	as needed	yes
TMA	quarterly reviews	no
4MCS	as needed	no
Newborn	no	no
RSM-Child	as needed	yes
RSM-Pregnant Women	month prior to the expected date of delivery and each month thereafter until termination of pregnancy	no
FM-MN	as needed	yes
CWFC	as needed	yes

Use the following chart to process a Medicaid Review. Refer to Chart 2710.1, Family Medicaid Reviews for COAs that do not require review.

Chart 2710.2 - Procedures for Dispositon of the Medicaid Review	
IF	**THEN**
the AU complies with all requirements	continue eligibility, if appropriate.
the AU misses the appointment and does not contact the agency	determine if Medicaid eligibility for any other COA can be established without completing this review.
the AU misses the appointment and contacts the agency within 24-hours	reschedule the appointment.
the appointment is missed and the AU contacts the agency within the timely notice period	reschedule the appointment.
the agency did not provide written notice of the appointment 10 days prior to the appointment date and the appointment is missed	reschedule the appointment.
the AU fails to provide requested verification	determine if Medicaid eligibility for any other COA can be established without the requested verification. If so, continue eligibility under the new COA. If no, send timely notice and close the Medicaid case following expiration of the timely notice period.
the AU fails to return the Alternate Review Form	determine if Medicaid eligibility for any other COA can be established without completing this review. If not, send timely notice. Close the case following expiration of the timely notice period.
the review is overdue	complete as a standard review. **EXCEPTION:** Complete an alternate review when the alternate review form is completed by the A/R and received by the agency no later than the month following the month it was due.
the case is transferred from another county	complete a standard review within 30 days of accepting transfer.

2712 – FAMILY MEDICAID CHANGES OVERVIEW

POLICY STATEMENT	When a change in the AU's or BG's circumstances occurs, DFCS must re-establish ongoing eligibility based on the new circumstances.
BASIC PROCEDURES	AUs must report all changes within 10 calendar days of the date the change occurs. The date the change occurs is the day the event actually happens. Examples include the following: • the date the first paycheck is received • the date the paycheck reflecting a change in pay is received • the date the unearned income is first received • the date the A/R becomes aware she is pregnant. **NOTE:** This list is not all-inclusive. Changes may be reported in any of the following ways: • in person • by telephone • by mail • by email • by facsimile • by system update Medicaid cards are printed in the week of the 25th of the month. Changes must be made prior to the 20th of the month to ensure the changes will be reflected on the Medicaid card for the following month. Changes must be reported within 10 days. The worker must take action based on the change as soon as possible, but no later than 10 days after the report. If the AU fails to report a financial change within 10 days, the agency must determine when the change should have been effective, based on the time frames specified above.

BASIC CONSIDERATIONS (cont.)	Changes are effective the month after the change occurs or the second month, depending on when the AU reports the change, when DFCS takes action and when timely notice expires. Ineligibility of an individual or an entire AU occurs the month after the required timely or adequate notice expires and a Continuing Medicaid Determination has been completed. **EXCEPTION:** Individuals approved for Emergency Medical Assistance (EMA) have specific days of eligibility. There is no penalty for late reporting in a Family Medicaid case. Financial changes do not affect Medicaid eligibility for pregnant women. Refer to Section 2184, RSM Pregnant Women and Section 2720, Continuous Coverage for Pregnant Women.
PROCEDURES	Follow the steps below to process changes.
Step 1	Document the reported change.
Step 2	Determine if the change is reported timely or untimely.
Step 3	Determine if verification is necessary. Request that the AU provide verification within 10 days. Refer to Chart 2712.1, Required Verification.
Step 4	Take appropriate action based on the change reported.
Step 5	Provide the AU with appropriate notice of action taken. Refer to Section 2701, Notification.

Use the chart below to determine if verification is required when an AU reports a change.

CHART 2712.1 - REQUIRED VERIFICATION	
CHANGE	**FAMILY MEDICAID**
income - new source	client statement, unless questionable
income - amount changes	client statement, unless questionable
vehicle - acquisition of	client statement, unless questionable
real property - acquisition of	client statement, unless questionable
life insurance - acquisition of	client statement, unless questionable
resource - all other changes in or acquisition of	client statement, unless questionable
AU size	client statement, unless questionable
dependent care costs	client statement, unless questionable
medical expenses	FM-MN: yes all other FM COAs: client statement, unless questionable
medical verification of pregnancy	yes
pregnancy **due date**	client statement, unless questionable
other factors of eligibility	client statement, unless questionable
residence	client statement, unless questionable
excluded income, i.e., vendor payments	client statement, unless questionable

Use the following chart to determine procedures when an AU fails to provide requested verification.

2712.2 - FAILURE OF A FAMILY MEDICAID AU TO PROVIDED REQUESTED VERIFICATION	
IF THE AU FAILS TO PROVIDE VERIFICATION OF:	**THEN**
a change in income OR a new source of income OR questionable information	terminate benefits effective the month following the expiration of timely notice. Complete a CMD prior to terminating Medicaid. **NOTE:** Any change in income must be reported within 10 days.
a new medical or dependent care expense	do not allow the dependent care expense as a deduction. Do not use the medical expense in the MN spenddown computation.
an increase in dependent care expense	remove the dependent care expense deduction from the benefit calculation.
a decrease in dependent care expense	remove the dependent care expense deduction from the benefit calculation.

2713 - FAMILY MEDICAID CHANGE OF RESIDENCE

POLICY STATEMENT	When the AU moves, changes are made to ensure benefits are received at the correct address.
BASIC CONSIDERATIONS	Make address changes on the day they are reported to the agency to ensure that benefits are sent to the correct address. Accept the client's statement as verification, unless questionable. Determine if the AU still resides in the county or the state when any address change is reported. Review household composition when the AU reports a change in residence. Offer Voter Registration services to each A/R at each face-to-face contact for report of change of residential address. Refer to Section 2980, Voter Registration.
PROCEDURES	
Change in Address	Document the following: • the date the AU or BG moved • the new address • method of verification (client statement or other, if questionable) • the date the new address was reported to the agency • the AU or BG members who reside at the new address • the names of others who may be living at the new address and their relationship to the AU or BG members. Make the address change effective with the ongoing month. Determine whether the AU or BG composition has changed. If so, make appropriate additions or deletions according to Section 2714, AU Composition Changes. Determine whether the address is in the county where the case is currently assigned. Follow procedures for transferring the case if the address is in another county.

PROCEDURES (cont.)

Make appropriate system changes to update the address.

Notify the new county of residence, if applicable, within 5 days and provide the following information:

- the new address
- the class of assistance
- the case number and name

Request that the new county of residence accept transfer of the case.

Within five days, mail the complete case record to the new county of residence.

The county to which the case was transferred must complete an alternate review within 30 days of completion of the transfer if a standard review was completed within 12 months prior to the month in which the case is accepted. If a standard review has not been completed within the prior 12 months, complete a standard review.

EXCEPTION: Standard reviews are not a requirement of RSM.

AU Moves Out of State

Document the following:

- the date the agency became aware of the AU leaving the state
- the source of information regarding the AU moving from the state.

Change the address, terminate benefits and provide adequate notice.

2714 – FAMILY MEDICAID AU COMPOSITION CHANGES

POLICY STATEMENT	Any change in the composition of an AU or BG must be evaluated in terms of eligibility.
BASIC CONSIDERATIONS	Individuals who are added to an AU must meet all eligibility requirements.
PROCEDURES	Evaluate the size and composition of the AU or BG when an individual moves into or from a residence. Determine whether an individual is required to be included in the AU when s/he is added to the AU. Complete the following procedures when an individual is added to the AU or BG. • Process a new application on the new member, using normal processing and notification procedures. • If the income and, if applicable, the resources of an individual required to be included in the BG are not established, Medicaid must be terminated. **EXCEPTION:** Medicaid is not terminated for a pregnant woman if she is receiving RSM or is eligible under Continuous Coverage. Refer to Section 2720, Continuous Coverage for Pregnant Women. Follow the steps below to add an individual to a Family Medicaid case. **Step 1** Obtain a signed application to add the individual. **Step 2** Determine if the individual is required to be added to the BG. **Step 3** If the individual is required to be added to the BG only, add the month after a timely or adequate notice. If adding the individual causes ineligibility of the AU, complete a CMD and terminate Medicaid.

PROCEDURES (cont.)	
Step 4	If the individual is to be added to the AU, determine all points of eligibility for the appropriate COA.
Step 5	Explore three months prior Medicaid eligibility.
Step 6	Begin Medicaid eligibility for the new AU members with the month s/he began living with the AU and for retroactive Medicaid eligible months.
Changes in AU Composition: Adding an AU Member	Compute a trial budget to determine ongoing eligibility. Include the new member's income and resources in the trial budget. If the AU is ineligible based on the trial budget, complete the following procedures: • complete a CMD • terminate Medicaid • notify the AU If the AU is eligible based on the trial budget, complete the following procedures. • schedule a face-to-face interview, if required. • establish all points of eligibility • request necessary verification • complete mandatory forms If the individual is required to be in the BG only, add the individual and his/her income and resources, if applicable, the month after the change is reported. If the individual requests to be part of the AU, have the individual or caretaker sign an application. If eligible, add the individual effective the month of the request and determine the need for Medicaid for any of the three months prior to the month the application is signed. Approve for any of the three prior months, if eligible. If ineligible for Three Months Prior, provide notification.

PROCEDURES
(cont.)

Changes in AU Composition: Birth of a Child	Document the following: • the birth of the child • the date the change is reported to the agency • the name of the child • method of verification (client statement or other verification) Establish that the child continues to live with the mother. The mother's statement is acceptable verification. Approve LIM, if eligible. If ineligible for LIM, approve Newborn Medicaid effective the month of the child's birth and ongoing pending contact with the mother. **NOTE:** A signed application is **not** required if the child is eligible for Newborn Medicaid COA.
Changes in AU Composition: Non-Custodial Parent (NCP) Returns Home	Document the following: • the date the parent returned to the home • the date the change is reported to the agency • the name of the parent and information regarding basic eligibility criteria • the parent's income and resource information • method of verification (client statement or other verification)
Changes in AU Composition: AU Member is Penalized	Notify the AU of the penalty and the effect on Medicaid eligibility. Allow timely notice. Budget the income and resources of the penalized individual according to the guidelines in Section 2657, Penalized Individuals. Remove the penalized individual effective the month following the month the agency determines the penalty. Allow timely notice. The penalized adult remains in the BG but not the AU unless she is a pregnant woman. Reinstate Medicaid beginning with the month of compliance.

PROCEDURES (cont.)

Changes in AU Composition: AU Member Becomes SSI Eligible

Document the following:

- the date SSI is approved
- the date the change is reported to the agency
- the date the change occurred
- the name of the person receiving SSI
- the amount of the SSI benefit and whether RSDI is received
- method of verification (client statement or other verification)

If RSDI is received, determine if dependents of the SSI individual also receive or are potentially eligible to receive RSDI.

Make the SSI recipient ineligible effective the month after the change is reported. Provide adequate notice.

DO NOT consider the income and resources of the SSI individual in the Family Medicaid budget.

Change in AU Composition: AU Member Leaves the AU

Document the following:

- the name of the individual who left the AU or BG
- the date the individual left the AU or BG
- the date the AU reported the change to the agency
- method of verification (client statement or other verification)

Remove the individual and his/her income and resources effective the month after the change is reported and timely notice expires (if required).

NOTE: If removing the individual causes ineligibility of AU under the current COA, complete a CMD. Terminate Medicaid if no COA exists for the remaining AU members or at the recipient's request.

PROCEDURES (cont.)

Changes in AU Composition: AU Member Reports Marriage

Determine when the change occurred.

Determine the relationship of all AU members to the new spouse.

Determine if the new spouse is required to be included in the AU.

The new spouse must be included in the AU or BG if s/he is the parent of an AU child. Refer to NCP Returns Home in this section.

If the new spouse is a stepparent or the spouse of a minor in the AU, compute a trial budget to determine ongoing eligibility. Refer to Section 2661, Responsibility Budgeting.

If the AU is ineligible based on the trial budget, complete the following procedures.

- complete a CMD
- terminate Medicaid after allowing timely notice
- provide adequate notice to the AU

If the AU is eligible based on the trial budget, budget the new spouse's earnings, approve Medicaid and notify the AU.

2715 – FAMILY MEDICAID CHANGES IN INCOME

POLICY STATEMENT	When a change in the AU's or BG's income and circumstances occurs, ongoing eligibility must be determined.
BASIC CONSIDERATIONS	A change in financial circumstances is defined as a change in income and/or expenses that affects the ongoing benefit amount. A change in circumstances includes the following types of changes (list is not all-inclusive): • Income begins or ends • Change in employers or obtaining additional employment • Increase or decrease in the rate of pay • Increase or decrease in the dependent care expense due to a change in provider, number of hours of care, number of individuals for whom care is given, or amount charged • Change in type of self-employment activity. A change in financial circumstances requires a recomputation of a representative income amount and a calculation of the best estimate of income based on the AU's past, current, and anticipated circumstances. The representative income is an amount of income that best represents what the AU is most likely to receive in each pay period and is used to calculate the AU's monthly income. Normal fluctuations in the income amounts are not considered a change in circumstances and do not require a recomputation of the representative income amount. Normal fluctuations include the following: • overtime not expected to last for more than one calendar month • a fifth or periodic paycheck • vacation pay received within a calendar month.

PROCEDURES

Earned Income: New Earnings

Document the following:

- date the change is reported to the agency
- who is employed and where s/he is employed
- when employment began
- the date of the first paycheck
- the estimated number of hours per week of employment and hourly wages
- the frequency of pay
- the date of the week paid
- the source of verification
- dependent care expenses
- third party resource
- method of verification (client statement or other verification)

If the AU is ineligible based on the trial budget, complete the following:

- complete a CMD
- terminate (if applicable)
- issue a timely notice.

If the Family Medicaid AU is eligible based on the trial budget, using anticipated income and expenses, complete the following procedures:

- establish representative pay
- budget the income effective the month following the expiration of timely notice and after verification is received, if required

Continue Medicaid for the AU members in Family Medicaid other than FM-MN.

In Family Medicaid-Medically Needy (FM-MN) cases:

- Recalculate all income received and calculate prospective income for each month remaining in the budget period.
- If the budgeted income places the case in spenddown status or increases the spenddown amount, change the case status in the system and notify the AU

Request the BG to submit any medical bills not covered by Medicaid to apply to the spenddown. If budgeted income does not change the eligibility status, document the record.

PROCEDURES
(cont.)

Loss of Income or Decrease in Income	Document the following: • the type of change • the effective date of the change • the date the change is reported to the agency • method of verification (client statement or other verification) Remove or decrease the income the month after the change occurs and is reported. If the AU is in MN spenddown, recompute the spenddown. **NOTE:** Explore all benefits to which the AU may be entitled.
Increase in Income	Document the following: • the effective date of the change • the date the change is reported to the agency • the type of increase (number of hours, rate of pay) • the amount of the increase • method of verification (client statement or other verification). Complete a trial budget to determine ongoing eligibility. If the AU is ineligible based on the trial budget, complete the following procedures: • complete a CMD • terminate Medicaid allowing timely notice • notify the AU. If the AU is eligible based on the trial budget, complete the following procedures: • budget income effective the month following the expiration of timely notice • if the AU is MN, recompute the income for the budget period. If the increased income affects spenddown, notify the AU. Change eligibility in the system as appropriate.

PROCEDURES
(cont.)

Change in the Source of Income

Document the following:

- the date the change in income is reported to the agency
- the date that the new or changed income is first received
- who receives the income
- the source and type of the new income
- the frequency of the income and day of the week received
- the amount of the income
- method of verification (client statement or other method)

Complete a trial budget to determine ongoing eligibility.

If the AU is ineligible based on the trial budget, complete the following procedures:

- complete a CMD
- terminate Medicaid. Allow timely notice and notify the AU.

If the AU is eligible based on the trial budget, complete the following procedures;

- request verification, if necessary
- determine ongoing eligibility by establishing representative pay, and, if appropriate, converting this income using the correct conversion factor for the ongoing benefit month. Refer to Section 2653, Prospective Budgeting.
- notify the AU
- if the AU is FM-MN, recompute the income for the budget period. If the change in income affects spenddown, notify AU and make the necessary changes to the case.

Unearned Income: Child Support Income

Document the following information if child support is reported as a new source of income or a change in child support is reported:

- the date the change is reported to the agency
- the date the new child support or change in child support was first received by the AU
- the frequency of receipt of the income
- the day of the week it is received
- the amount of the income
- who pays the child support and for which child
- method of verification (client statement of other verification).

PROCEDURES

Unearned Income: Child Support Income (cont.)

Calculate a trial budget to determine ongoing eligibility.

If the AU is ineligible based on the trial budget, complete the following procedures:

- if receiving LIM, change the COA to Four Months Medicaid due to Child Support (4MCS) if all 4MCS requirements are met.

  NOTE: If the increase in child support occurs concurrently with an increase in earned income, TMA may be approved. Refer to Section 2166, Transitional Medical Assistance.

- complete a CMD
- if ineligibility will only last for one month, suspend benefits. Offer MN before suspending benefits.
- notify the AU and allow timely notice.

If the AU is eligible based on the trial budget, complete the following procedures:

- determine the amount of child support and add the child support to the budget
- allow timely notice
- notify the AU.

NOTE: Notify CSE of direct child support unless the AU is child-only. Refer to Section 2250 for the definition of a child-only case.

Unearned Income: Loss of Child Support

Document the following:

- the date the AU or BG last received child support
- the date the loss of child support is reported to the agency
- the reason for the loss of child support, if applicable.

  NOTE: If the loss of child support is because of the death of the NCP, explore eligibility for other benefits.

- method of verification (client statement or other verification).

Delete the child support income for the ongoing benefit month and notify the AU.

NOTE: For FM-MN AUs, consider the effect of the loss of child support on spenddown status.

PROCEDURES
(cont.)

Changes in Deductions to Income

Consider the effect of the following on eligibility;

- a change in dependent care expenses
- a change of medical expenses (FM-MN only)
- expiration of the $30 plus 1/3 deduction because of time limitations.

Document the following:

- the type of deduction that changed
- the date the change occurred
- the date the change is reported to the agency
- how the deduction changed
- method of verification (client statement or other verification).

Complete a CMD, if necessary. Recompute the budget, including the new deduction amount.

Provide timely notice of any change(s) to the AU.

2716 – FAMILY MEDICAID MISCELLANEOUS CHANGES

POLICY STATEMENT	Other changes may occur which may require action. Evaluate reported changes for necessary action.
Mass Changes	Mass changes affect all or a large number of AUs receiving benefits. These changes may include the following: • adjustments to income limits • adjustments to dependent care deductions • cost of living adjustments to SSA, SSI, VA and other benefits • other changes based on legislative or regulatory actions. Mass changes are generally completed by systems changes and require no eligibility worker (EW) intervention. Adequate notice is required. Cases affected by the mass change but not updated by the system may require the worker to initiate a change. A list is generated to notify the EW which cases will not be updated in the mass review so that the EW may take appropriate and timely action.
Closure: AU Request Closure	Document the following: • the reason for the closure • the date the closure is requested. Terminate ongoing benefits after giving timely notice. **NOTE:** If the request for closure is in writing, only adequate notice is required.
EDD Contact on Pregnant Women	Complete the following procedures in contacting a pregnant woman each month beginning with the month prior to the EDD: • Contact the pregnant woman by telephone, letter or face-to-face. • Establish by the A/R's statement that the pregnancy continues, reminding the pregnant woman to notify the agency when the pregnancy terminates. Also, remind the pregnant woman of her right to apply for TANF 45 days prior to the expected date of delivery. • Continue to contact the pregnant woman each month until the pregnancy terminates.

EDD Contact on Pregnant Woman (contd.)	When a pregnancy terminates, continue Medicaid through the 60-day transition period. If the termination results in a birth, approve LIM for the mother and baby or, if ineligible for LIM, approve Newborn Medicaid. Refer to Section 2174, Newborn Medicaid.
Processing 60-Day Transition Medicaid	Complete the following procedures to process 60-day transition Medicaid when pregnancy terminates for a Medicaid eligible pregnant woman. • Determine date of termination. • Count the 60 days beginning with that day. • Continue Medicaid for the pregnant woman through the month in which the 60th day falls. • Begin a CMD by the 30th day of the transition period and complete the process by the 40th day. • If Medicaid eligibility does not continue, terminate Medicaid on the pregnant woman. Send timely notice.
Processing Newborn Medicaid	When a pregnancy terminates with the birth of a child, use the following procedures to process eligibility for the newborn: • Determine if LIM eligibility exists. • If ineligible for LIM, establish that mother was eligible for and receiving Medicaid on the day the child was born. Refer to Section 2174, Newborn Medicaid for the definition "receiving Medicaid on the day the child was born". • Approve Newborn Medicaid for the month of birth and ongoing pending contact with the mother. • Contact the mother to determine if the child continues to live with her. • Continue ongoing Medicaid for the child if eligible. If ineligible, complete a CMD. • Discuss third party liability and complete Form DMA-285, Third Party Resources, if possible. • Begin a CMD in the 12th month of Newborn eligibility and complete the process by the 10th of the 13th month of eligibility. • If a child is eligible under another COA, process as required. Complete a review, alternate or standard, to determine all points of eligibility. If eligibility continues, approve the child under the appropriate COA. If eligibility does not continue under any COA, provide a termination notice.

RSM Child Reaches an Age Limit

Use the following procedures when a RSM child reaches an age limit in RSM.

- In the month prior to the month in which the RSM child reaches age 1 or age 6, contact the A/R to update income information and to inquire about any other changes.
- For a child receiving inpatient services in the month s/he reaches an age limit, refer to Section 2182, RSM Child.
- Complete a new budget using the appropriate RSM income level for the child's age.
- If eligibility continues, send a notice to inform the AU of the change in eligibility.
- If over the RSM income limit, refer the AU to PeachCare for Kids.

NOTE: when a RSM child reaches the 19-year age limit, complete a CMD. Begin this process in the month prior to the individual's 19th birthday and complete the CMD by the 10th of the last month s/he will be 19 years old.

Changes in MN Case During the One Month Budget Period

Use the following procedures to re-calculate eligibility for Medicaid when an A/R reports any of the following changes in a MN case during the one month budget period:

- an increase or decrease in income
- a change in BG size
- additional medical expenses
- a decrease in resources
- a change in dependent care expenses

NOTE: The result of any of these changes may cause the AU to become eligible earlier in the budget period month, may cause the case to go from eligible for Medicaid to spenddown status, or may increase or decrease the spenddown.

- Request verification of the change if required.
- Determine the actual income that has been received and/or the BG size for the budget period.

Changes in MN Case During the One Month Budget Period (cont.)

- Anticipate income and expenses for the remainder of the budget period.
- Determine BG composition for the budget period.

  NOTE: If a BG member was living in the home at any time in the month, count this individual in determining the BG size.
- Re-calculate eligibility.
- Subtract any allowable deductions from the total income
- Subtract the MNIL from the net income.
- If the result is equal to or less than the MNIL, approve or continue de facto eligibility.

  NOTE: If this change results in de facto eligibility, the case becomes eligible for Medicaid in the month the change occurred.
- If the result exceeds the MNIL, this is the spenddown amount. Apply any incurred medical expenses chronologically to this spenddown. If spenddown is met, approve MN for the AU on the day spenddown is met. Provide Form 400, as required. If spenddown is not met, return the case to spenddown status or continue spenddown the following month.
- Notify the AU of any action on the case.

Other Changes in a MN Case

When the pregnant woman in a MN case reports termination of pregnancy, use the procedures in Chart 2716.1 to process Medicaid.

CHART 2716.1 – OTHER CHANGES IN A MN CASE	
IF	THEN
the pregnant woman was correctly approved for Medicaid	provide 60-day pregnancy transition Medicaid.
the pregnant woman's case was in spenddown status and the bills incurred on the day of the termination of pregnancy met spenddown	verify all actual income and expenses that have been received for the budget period and anticipate income and expenses for the remainder AND recalculate the budget and all incurred medical expenses in chronological order AND approve Medicaid the day spenddown is met through the 60-day pregnancy transition, even if it extends beyond the budget period AND provide Form 400 as needed. **NOTE:** If spenddown is not met until the date after the termination of pregnancy, the pregnant woman is ineligible for Medicaid and the child cannot receive Newborn coverage.
if the mother is or becomes Medicaid eligible	approve the child for Newborn coverage.

If an A/R submits an unpaid medical expense that was incurred during or prior to the budget period after the budget period has expired, apply the bill to the spenddown if the following two conditions are met:

- spenddown for the budget period will be met or adjusted by allowing this expense
  AND
- the bill is presented within three months of the expired Budget Period.

If these conditions are met, follow the procedures in this chart.

NOTE: If the three month time limit has passed, allow the bill in any current or future budget period if the BG member is still legally obligated to pay the bill and there is no Third Party Resource coverage available.

2720 - CONTINUOUS COVERAGE FOR PREGNANT WOMEN

POLICY STATEMENT	A pregnant woman, adult or minor, who becomes ineligible for Medicaid because of an increase in income of any Assistance Unit (AU) or Budget Group (BG) member is eligible for Medicaid for the remainder of her pregnancy and though the 60-day pregnancy transition period.
BASIC CONSIDERATIONS	Continuous coverage for a pregnant woman applies in the following situations: • a pregnant woman who becomes ineligible for SSI because of an increase in income • a pregnant woman who becomes ineligible for any Medicaid COA because of an increase in income. **NOTE:** A pregnant woman receiving Medicaid under RSM PgW COA remains eligible for RSM PgW through termination of the pregnancy and the 60-day transition period, regardless of financial or non-financial changes that occur during the pregnancy. **EXCEPTION:** If the pregnant woman no longer meets the Georgia residency requirement, Medicaid is terminated, regardless of COA. For continuous coverage purposes, an increase in income includes any one of the following: • an increase in the AU's or BG's countable income • receipt of a lump sum by a BG member • a decrease or loss of earned income deductions • a decrease in dependent care expenses • a decrease in the number of individuals included in the AU and/or BG • the addition to the AU and/or BG of an individual with income • expiration of the MN budget period if the pregnant woman was Medicaid eligible or would have been if her pregnancy was known • any other change that results in excess income. Continuous coverage for a pregnant woman includes reinstatement of Medicaid if a voluntary closure or other termination has occurred, whether or not the pregnancy was known at the time of termination.

BASIC CONSIDERATIONS (cont.)	A pregnant woman approved for EMA is not eligible for the automatic 60 transition Medicaid. She may, however, qualify for additional days of EMA during that 60 day period if she receives pregnancy-related emergency treatment. Refer to Section 2184, RSM Pregnant Woman.
PROCEDURES	Use the following procedures to establish continuous coverage eligibility for a pregnant woman:
Step 1	Determine that the pregnant woman is ineligible to continue Medicaid under the current COA because of an increase in AU/BG income. OR Determine that a pregnant woman is ineligible for SSI because of an increase in income. The following sources may be used to verify SSI ineligibility: • SSI notification letter • State Data Exchange (SDX) • other verification from the Social Security Administration
Step 2	Establish that the woman was pregnant in the last month of SSI of Medicaid eligibility.
Step 3	Determine that the pregnant woman met the non-financial eligibility requirements in RSM PgW in the last month of eligibility for the COA under which Medicaid is being terminated. **NOTE:** If a Medicaid case was closed, determine that the pregnant woman met the non-financial eligibility requirements for RSM PgW in the last month of Medicaid eligibility and that she continues to meet these requirements.
Step 4	Complete any mandatory forms required for RSM PgW. **NOTE:** Do not require a new application.
Step 5	Approve RSM PgW if the pregnant woman is/was receiving Medicaid under a COA other than RSM PgW.

SPECIAL CONSIDERATIONS

If a pregnant woman becomes ineligible for Medicaid for a reason other than an increase in BG income, she is eligible for continuous coverage if both of the following conditions exist:

- the pregnant woman met RSM PgW eligibility criteria during the time she received Medicaid under another COA

AND

- she could have been approved for continuous coverage under RSM PgW because of an increase in BG income.

2750 - CASE MANAGEMENT REPORTS OVERVIEW

POLICY STATEMENT	Periodic reports are generated by the Division of Medical Assistance (DMA) and forwarded to local DFCS offices for appropriate action.
BASIC CONSIDERATIONS	The reports being generated by DMA are categorized in two types and identified as Continuing Medicaid Determination Reports and Informational Reports. The report names and purpose are defined as follows. Federal policy requires a continuing Medicaid determination (CMD) of eligibility under all Medicaid coverage groups on SSI terminations. As part of the CMD process for A/Rs terminated from SSI, DMA will determine if continued eligibility exists and move A/Rs to the new Medicaid coverage group. Reports for each coverage group will be generated by DMA and mailed to local DFCS offices. The reports are listed below and require immediate action by DFCS. • Recipients Changed from SSI/DMP to MAO • SSI Disabled Adult Child (DAC) Report • Disabled Widow/Widowers Termination Report • SSI to Disabled Children (Section 4913) Report • SSI to Pickle Report • SSI Termination/QMB Eligible Determination Report • SSI Termination/SLMB Eligible Determination Report • SSI Terminations to RSM Report The following reports generated by DMA are informational and may require action in a timely manner, if not previously taken by DFCS: • Cases Pending Due to Non-Receipt of Confirmation Transaction (Nursing Home or PL 94-566) • Ineligible Nursing Home Recipient Report • Monthly Discharge/Death Report Prebill Information • Newborn Report • Presumptive Eligibility Report
PROCEDURES	Refer to the specific section in this chapter for procedures on processing both types of reports.

2752- DMA CONTINUING MEDICAID DETERMINATION REPORTS

POLICY STATEMENT

A continuing Medicaid determination (CMD) of Medicaid eligibility under all coverage groups is required on all SSI terminations before Medicaid can be terminated by DMA.

BASIC CONSIDERATIONS

As part of the CMD process for A/Rs terminated from SSI, DMA will determine if continued eligibility exists and move A/Rs to the new Medicaid coverage group. Reports listing the names of individuals who are converted to a new coverage group will be generated and mailed to local DFCS offices. A separate report will be generated for each coverage group.

The reports are as follows and require a partial review of eligibility by DFCS within 10 days of receipt of the report.

- Recipients Changed from SSI/DMP to MAO
- SSI Disabled Adult Child (DAC)
- Disabled Widow/Widowers Termination Report
- SSI to Disabled Children (Section 4913) Report
- SSI to Pickle Report
- SSI Termination /QMB Eligible Determination Report
- SSI Termination/SLMB Eligible Determination Report
- SSI Termination to RSM Report

Each list will contain the individual's name, client ID, Social Security number, date of birth, mailing address and effective date of SSI termination.

NOTE: A complete redetermination of eligibility must be completed on all cases when a change is reported or within 12 months after the SSI termination, whichever comes first. Contact with the individual, either face-to face or by telephone, is not required to complete this process.

PROCEDURES

Follow the steps below upon receipt of one of the above reports from DMA.

Step 1 Screen all names on the report to determine if any A/R has an active Medicaid case with DFCS. Assign to an appropriate worker.

Step 2 Using SDX, BENDEX and any other available information register the case on the system under the COA specified by the report.

Assume SSA has forwarded TPR information to DMA.

PROCEDURES

Step 2 (cont.) Prior receipt of SSI is prima facie evidence of citizenship/alienage. Prior receipt of SSI is also prima facie evidence of disability for 12 months from termination of SSI if the A/R is under age 65 and SSI was not terminated for failure to meet the disability criteria.

For Public Law COAs, determine COLA and entitlement or increases in RSDI based on the SDX/BENDEX using the best estimate possible.

Step 3 Approve the case in the system within 10 days of receipt of the list unless available information determines the A/R to be ineligible.

Step 4 Deny the case in the system within 10 days if available information indicates the A/R is ineligible. Use the most appropriate denial reason available.

SSI/DMP to MAO Reports - Individuals Age 18 and Over

Assign the case to an ABD worker. If the A/R is in a nursing home, process the case under the nursing home COA in the system.

Approve the case and authorize vendor payment within 10 days using SDX and BENDEX if Forms 59 and DMA-6 have been received, or as quickly as these forms are received.

In the absence of evidence to the contrary, assume all other eligibility criteria have been met and that SSA has determined there have been no transfer of assets.

If the A/R is not in a nursing home, explore eligibility under all other ABD Medicaid COAs. In the event the A/R is only eligible for AMN, process the case and place in spenddown status. Contact the A/R by telephone or letter to explain the spenddown process. Refer to the topic *For All Cases – ABD and Family Medicaid* in this section for further instructions.

PROCEDURES (cont.)

SSI/DMP to MAO Reports – Individuals Under Age 18

Assign the case to a Family Medicaid worker to determine Medicaid under one of the Family Medicaid COAs.

If eligible, approve the case in the system within 10 days using available information on SDX/BENDEX. If more information is needed, contact the family by telephone or letter. Do **not** require a face-to-face contact.

If the A/R is not eligible under any Family Medicaid COA, deny the case in the system and refer the case to an ABD worker for potential ABD Medicaid eligibility.

For individuals under age 18 who are not eligible under a Family Medicaid COA, the ABD worker should register the case under the SSI Medicaid COA. Contact should then be made with the family by telephone or letter to determine potential eligibility for Deeming Waiver or Former SSI Disabled Child COAs. Refer to the topic *For All Cases – ABD and Family Medicaid* in this section for further instructions.

For All Cases - ABD And Family Medicaid

If the A/R is continued eligible, approve the case in the system within 10 days from the date of receipt of the report. Approvals processed in the system require no additional notification to DMA.

The county must complete a full review of eligibility within 12 months or when a change is reported, whichever is earlier.

If the A/R is found to be ineligible, deny the case on the system. Provide the A/R with timely notice via the system generated notice.

Notification to DMA via the email form found on the GO-Mail bulletin board entitled *Medicaid Forms* is required for cases which, based on the available information, are:

- ineligible for continued Medicaid, or
- which are approved for Medically Needy Spenddown but in suspense status, or
- which are pending further information (such as referrals to the ABD worker for a Deeming Waiver determination or RSM cases pending parent's statement of income).

Email notification to DMA must be made within 10 days.

PROCEDURES

For All Cases - ABD and Family Medicaid (cont.)

Notify DMA within 10 days via the e-mail form of any A/R on the report who, according to SDX, continues to be SSI eligible and in C01 status.

NOTE: Within 10 days is defined as *within 10 days from the receipt of the report by the county office.*

If a county receives a list and determines that the individual(s) on the list resides in another county, the receiving county shall forward a copy of the list to the appropriate county. Notify DMA and the receiving county via e-mail that the individual is a resident of that county.

Monitoring Procedures

All counties must keep a central file of all SSI CMD Reports generated by DMA. The county shall annotate for each name the action taken.

For all cases which are not approved for ongoing Medicaid in the system, the county shall create a case folder if one does not already exist. The county shall put in the folder a copy of the SSI CMD report, a copy of the SDX, BENDEX or other verification that was used to determine ineligibility, and a screen-print of the e-mail form sent to DMA notifying them of the status of the case.

2754 - DMA REPORTS

POLICY STATEMENT

Informational reports generated by DMA are designed to inform DFCS of circumstances affecting ABD Medicaid cases, which may be unknown by DFCS.

BASIC CONSIDERATIONS

The following reports are forwarded to local DFCS offices and require follow-up to determine if action needs to be taken.

- Cases Pending Due to Non-Receipt of Confirmation Transaction (Nursing Home or PL 94-566)
- Ineligible Nursing Home Recipients Report
- Monthly Discharge/Death Report Prebill Information
- Newborn Report
- Presumptive Eligibility Report

Names on the reports should be reviewed to determine if the information provided is previously known to the agency and if action has already been taken or if new action is required.

Each list should be annotated regarding action taken and filed in a central file in the county office.

PROCEDURES

Cases Pending Due to Non-Receipt of Confirmation Transaction

The purpose of this report is to advise that action was not taken by DFCS on an individual whose name appeared on the DMA CMD report.

Follow the steps below upon receipt of the report from DMA.

Step 1 Screen each name to determine if any A/R has an active Medicaid case. If the client is currently receiving Medicaid, no action is required. Annotate the list that the A/R is active.

Step 2 If the A/R is not currently Medicaid eligible, follow procedures pertaining to the SSI/DMP to MAO Report outlined in Section 2752, Continuing Medicaid Determination Reports.

PROCEDURES (cont.)

Ineligible Nursing Home Recipients Report

This list contains the names of A/R's for whom a nursing home is requesting Medicaid reimbursement and the A/R is either not showing as Medicaid eligible or as having a vendor payment authorized in DMA's recipient database.

Follow the steps below upon receipt of the report from DMA.

Step 1 For each name, review the INELIGIBLE DOS (date of service) and the INST screen in the system and identify the error.

Step 2 Once the error has been identified, take appropriate measures to correct and/or update information in the system.

NOTE: Examples of errors are prior months that did not get approved in the system at application and information keyed in error or failure to correctly update the INST screen in the system.

Step 3 After corrections have been made, follow-up with the nursing home to advise that the problem has been resolved and recommend they re-bill the claim with DMA.

If the A/R is ineligible for the DOS on the report, explain the reason for ineligibility to the nursing home.

Monthly Discharge/ Death Report Prebill

This list contains names of individuals who were discharged from a nursing home in the preceding month.

Follow the steps below upon receipt of the report from DMA.

Step 1 Determine if the following actions have been taken:

- Termination of the vendor payment
- Closure of the case if discharge is due to death
- A CMD
- Transfer of the case if the recipient moved to another county.

Step 2 Take the appropriate action if one of the items listed in Step 1 has not been completed.

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2801 - ASSISTANCE TO CHILDREN IN PLACEMENT OVERVIEW

POLICY STATEMENT

The Assistance to Children in Placement Chapter contains policy on Medicaid Classes of Assistance and procedures associated with children who are under the care and supervision of the state Child Welfare Agency.

BASIC CONSIDERATIONS

Children who are in placement may be eligible for Medicaid coverage through several classes of assistance. These include the following:

- IV-E Foster Care or IV-E Adoption Assistance
- SSI
- Child Welfare Foster Care
  or
  Right From the Start Medicaid (RSM)
  or
  State Adoption Assistance
- Medically Needy
- Emergency Medical Assistance (EMA)

Children who are IV-E or SSI eligible are automatically eligible for Medicaid. Therefore, eligibility for IV-E should always be considered first by the Eligibility Worker. If the child is not eligible for IV-E or SSI benefits, other classes of assistance should be considered in the order above.

The state receives reimbursement for administrative costs based on the total number of children eligible for IV-E. In order for a state to receive federal reimbursement for the foster care maintenance costs of an individual child in care, the child must meet both eligibility and reimbursability criteria. Initial eligibility is determined once, while reimbursability may change on a monthly basis depending on the placement, the child's income and other factors. A child who is non-reimbursable is also ineligible for administrative costs.

Coordination between the Social Services Case Manager (SSCM) and the Eligibility Worker (EW) is critical in determining coverage for children in placement.

BASIC CONSIDERATIONS

The SSCM is responsible for the following:

- Makes referral to the eligibility section on all children entering out-of-home care.
- Collects child and family data for the initial determinations of eligibility at the EW's request.
- Reviews court orders for the required judicial determinations and provides notification of the applicable court order dates to the EW.
- Provides notification of changes in placement and other eligibility factors to the EW and to Accounting.
- Initiates action with the Social Security Administration for children receiving SSI.
- Provides requested information/documentation to the EW for redeterminations.

The EW is responsible for the following:

- Determines initial eligibility for IV-E and other Medicaid classes of assistance.
- Notifies the SSCM if child and family data is needed for initial determination.
- Completes six-month redeterminations.

2805 - FUNDING SOURCES

POLICY STATEMENT

Maintenance and administrative costs for children in foster care are paid from several funding sources.

BASIC CONSIDERATIONS

The funding sources available are Title IV-E Foster Care, Supplemental Security Income (SSI), Title IV-B Foster Care, Medicaid and state funds. Federal funding sources are pursued because they share in the cost of foster care, conserving state funds.

Children in foster care are referred to Child Support Enforcement to determine if the parent can pay child support and/or medical expenses to offset placement costs.

IV-E Foster Care Funds

IV-E is the federal funding source designated for certain children who are under the care and supervision of the State Child Welfare Agency. IV-E provides reimbursement for costs associated with the care and maintenance of children in placement, and for administrative cost related to the State's foster care program. The IV-E Foster Care Program authorized by the Social Security Act, provides funds to states for the following activities:

- maintenance of children in foster care placements
- reimbursement of administrative and case management costs incurred while staff work with the child, the child's family and the care provider
- reimbursement for training agency staff and providers who work with the child or who administer the foster care program
- provides Medicaid for children in placement

All reimbursements are based on actual state expenditures.

All children entering foster care must be referred to the eligibility worker for IV-E eligibility determination. To be eligible for IV-E Foster Care maintenance and administrative costs, all IV-E requirements must be met.

Children classified as IV-E eligible must have some relationship to the Aid to Families with Dependent Children (AFDC) program, in addition to meeting other criteria. IV-E is unrelated to Temporary Assistance to Needy Families (TANF). In the Welfare Reform Act of 1996, Congress mandated that the state AFDC policy in effect on July 16, 1996 be used for determining the AFDC relationship for IV-E eligibility purposes.

BASIC CONSIDERATIONS (contd.)

IV-B Foster Care (Child Welfare Foster Care Funds)

The IV-B program is a federal child welfare block grant that provides funds to states for foster care expenses. A child who is eligible for IV-B is a child in placement for whom DFCS has partial or total responsibility and who has been determined ineligible for IV-E foster care. IV-B funding is limited and once exhausted, foster care expenses for a IV-B eligible child are paid primarily with state funds. It is advantageous to pursue IV-E FC for all children to conserve the use of state dollars.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a federal payment program for disabled individuals administered by the Social Security Administration. Payments are made directly to the recipient from the federal government on a monthly basis. When a child is in DFCS' custody, the county department becomes the payee for the child's SSI check. Children in care who are determined to have a serious mental, emotional or physical disability may receive SSI. Certain SSI eligible children may be concurrently eligible for IV-E payments.

Medicaid Program

The Medicaid program is a joint federal/state program, authorized under the Social Security Act that provides funds to states for the costs of providing medical services to eligible recipients. Funds are also provided for reimbursement of activities that support the administration of the Medicaid program. DFCS accesses Medicaid funds through the Department of Community Health, Division of Medical Assistance, for both child and adult protective services case management and therapeutic services in out-of-home care. MATCH placements are also partially funded with Medicaid funds. Children who are IV-E eligible and/or SSI eligible are automatically eligible for Medicaid. Children whose substitute care is paid by state funds are not automatically eligible for Medicaid, but may be determined eligible for Medicaid benefits. An eligibility determination must be completed on each child entering care.

2810 - FOSTER CARE MEDICAID APPLICATION PROCESSING

POLICY STATEMENT	The Foster Care Medicaid application process begins with the request for medical assistance from the local DFCS office and ends with the SUCCESS generated notification to the DFCS office of the eligibility determination.
BASIC CONSIDERATIONS	Once a child is taken into DFCS custody, the DFCS office will request medical assistance for the child through the RSM Project office. The DFCS office will make the request by using the designated fax form or by calling the toll free number (800) 809-7276. The RSM office will review fax or phone application and determine eligibility for RSM Medicaid. The DFCS office will receive notification of the decision by a SUCCESS generated letter. Upon request, a temporary Medicaid card, Form 964, can be faxed to the DFCS office. The case will be transferred to the DFCS office for ongoing case management. The DFCS office will have six months to review the RSM case for potential eligibility for Child Welfare and IV-E eligibility. **NOTE:** The child must be removed from all active or pending cases prior to being placed in RSM Medicaid.

RSM Project: Foster Care Medicaid Worker
409 Arrowhead Blvd., Ste. C-8
Jonesboro, GA 30236

FAX

To: **From:**

RSM Project Foster Care Medicaid Phone: (800) 809-7276 (770) 473-2612 (770) 473-2613 Fax: (770) 473-2620	Date: County DFCS: Phone: ( ) - Social Services Worker: Phone: ( ) -

Remarks:

Please complete all of the following information.

Name: _____ **Sex:** _____ **Race:** _____

Date of Birth: _____ **SS#:** _____

Citizen: ___**yes** ___**no** **If no, legal status:** _____

Income: ___**yes** ___**no** **If yes, source:** _____

amount & frequency: _____

Pregnant: ___**yes** ___**no** **If yes, fax verification**

Is child a minor parent? ___**yes** ___**no**

DFCS mailing address: _____

_____

Eligibility Worker : _____ **Phone number:** ( ) -

County/Load/Caseload ID for transfer to SUCCESS: _____/_____/_____

_____ _____

Signature of Person Making Referral **Title**

Do you need a faxed Medicaid card? ___**yes** ___**no**

If yes, list fax number: ( ) -

2812 - DEPARTMENT OF JUVENILE JUSTICE MEDICAID APPLICATION PROCESSING

POLICY STATEMENT	The Department of Juvenile Justice (DJJ) Medicaid application process begins with the request for Medicaid from the local DJJ office and ends with the SUCCESS system generated notification to the DJJ office of the eligibility determination.
BASIC CONSIDERATION	When a child is adjudicated delinquent and placed in an out-of-home facility pursuant to a delinquency court order, the DJJ Juvenile Probation/Parole Specialists (JPPS) will request Medicaid for the child through the DJJ eligibility worker (EW) designated for their region. The JPPS will make the request by using the DJJ RSM Request. The JPPS will fax the RSM application, social history face sheet, screening placement form, a copy of the court order and Form 297, Application for TANF, Food Stamps or Medical Assistance to the appropriate Regional DJJ EW. The DJJ EW will review the fax, determine eligibility for RSM and input the determination into SUCCESS. The DJJ EW will notify the JPPS of the eligibility determination by e-mail. The SUCCESS system will generate a notice to the JPPS of the eligibility determination. Upon request, a Form 964, Certification of Medicaid Eligibility can be faxed to the JPPS. The JPPS will provide all pertinent information to the DJJ EW for a determination of potential IV-E eligibility. If the child is determined IV-E eligible, the DJJ EW will document SUCCESS and make the appropriate changes. The EW will send notification to the JPPS of the results of the IV-E eligibility determination. The DJJ EW will maintain all DJJ cases for ongoing case management. When a child leaves DJJ custody, the DJJ EW will complete a CMD.

DJJ RSM Request FAX

To:

Phone: ( ) -

Fax: ( ) -

From:

Date: _____

County DJJ CSO: _____

DJJ Worker: _____

Mailing Address: _____

_____

Phone: ( ) -

Fax: ( ) -

Remarks:

Please complete all of the following information.

Name: _____ **Sex:** _____ **Race:** _____

Date of Birth: _____ **SS#:** _____

Citizen: ___yes ___no **If no, legal status:** _____

(Need Resident Alien Card)

Income: ___yes ___no **If yes, source:** _____

Amount & frequency: _____

Pregnant: ___yes ___no **If yes, fax verification**

Is child a minor parent? ___yes ___no **Child has insurance?** ___yes ___no **(attach card)**

Child is currently at: _____

Child is recommended for: _____

Do you need a faxed Medicaid card? ___yes ___no

If yes, list fax number: ( ) -

Signature: _____ **Date:** _____

(Attach the following with this form: screening placement form, social history face sheet and copy of court order.)

2815 - IV-E FOSTER CARE MEDICAID

POLICY STATEMENT

IV-E Foster Care Medicaid provides coverage to children in placement for whom DFCS has partial or total custody and who are eligible for IV-E Foster Care.

BASIC CONSIDERATIONS

IV-E Eligibility Criteria

The following criteria must be met for a child to be IV-E eligible:

- The child entered care as a result of a court order with a judicial determination to the effect that it is *contrary to the welfare of the child to remain in the home,* or that placement is *in the best interest of the child,* or by a signed Voluntary Placement Agreement. This is usually the order that is issued as a result of the 72-hour hearing. The contrary to the welfare determination must be made in the initial order that sanctions the removal of the child. If the judicial determination is not made, the child is not eligible or reimbursable for the duration of that stay in foster care. There must also be a judicial determination within 60 days of removal to the effect that *reasonable efforts were made to prevent removal of the child* or that *reasonable efforts were not required to prevent removal of the child.* The child is not IV-E eligible until the reasonable efforts language is obtained. If the judicial determination is not made within 60 days of the child's removal from home, the child is not IV-E eligible or reimbursable for the entire placement episode. For those children who enter DFCS care and responsibility via a voluntary placement agreement, a judicial determination that reasonable efforts to prevent removal is not required for meeting IV-E eligibility. See Section 2820, Legal Status.

- The child must meet the following AFDC relatedness criteria in the eligibility month:

  - living with specified relative
  - deprivation
  - financial need: income and resources
  - U.S. citizen/legal alien
  - age

The eligibility month is the month the Voluntary Placement Agreement was signed by both parties or the month the petition that led to the removal of the child was filed.

BASIC CONSIDERATIONS

IV-E Eligibility Criteria (cont.)

A child who meets all eligibility criteria is IV-E eligible. Title IV-E eligibility is determined each time a child first comes into the care and responsibility of DFCS via a court order or VPA. Eligibility does not automatically grant federal benefits for maintenance costs. Once established, a child's eligibility continues as long as the child remains in the same placement episode.

EXCEPTIONS: A child loses IV-E eligibility at age 18; the child is in care under a Voluntary Placement Agreement (VPA) and a custody order with a judicial determination to the effect that *continued placement is in the best interest of the child* statement was not obtained within 180 days of the signed VPA; or the child is on trial home visit or run away status beyond six months, unless a court orders a longer trial home visit.

A child must be determined IV-E eligible in order to be determined IV-E reimbursable. Initial IV-E eligibility is based on the circumstances in the home from which the child was removed, via a custody order or Voluntary Placement Agreement. If a child is determined not eligible for IV-E, the child is ineligible for the duration of the placement episode for both IV-E eligibility and IV-E reimbursability. A placement episode begins at the same time the child enters foster care to the point DFCS terminates custody. When a child re-enters DFCS placement, a new placement episode begins.

The determination that a child is IV-E reimbursable allows the State to obtain federal IV-E funding for the administrative and training costs associated with the child.

IV-E Eligibility Effective Date

The effective date of IV-E eligibility is the first day of the month in which all of the eligibility criteria are met. A child who is IV-E eligible during any part of the month is eligible for the entire month.

PROCEDURES

Follow the steps below to determine IV-E Foster Care Eligibility.

Step 1 Conduct an interview with the SSCM, establishing basic eligibility. Obtain a Form 297, Application for TANF, Food Stamps or Medical Assistance.

Step 2 Verify from the SSCM that the child is in a licensed/approved foster care placement.

Step 3 Obtain a Form 713, Interagency/Interoffice Referral and Follow-up, from the SSCM to verify the following information:

- the date the petition for custody was filed, if obtained
- the date of the court order or voluntary placement agreement.

NOTE: Terminate IV-E FC eligibility for a voluntary placement unless a judicial determination is made within the 180 days of the date the agreement was signed.

- assurance of the required wording in the court order or validity of the voluntary placement agreement
- the name of the agency or individual to whom the court order gives responsibility for placement of a child
- the date the court order or voluntary placement agreement expires
- the name and address of the placement source.

Step 4 Establish deprivation and financial need by determining the child's eligibility for AFDC (based on 7/96 AFDC policy). Verify that the child meets the AFDC criteria for initial IV-E eligibility in the month that the petition for custody was filed or the Voluntary Placement Agreement was signed.

See Section 2825, AFDC Relatedness.
See Section 2845 if the child receives SSI.

NOTE: If the child did not live with a specified relative in the eligibility month, determine if s/he lived with a specified relative in any one of the six months prior to the month in which the petition for custody was filed or the voluntary placement agreement was signed. Determine if the child could have received AFDC in the home in the removal month if the child had been living with the specified relative from whom custody was removed.

PROCEDURES (cont.)

Step 5 Accept the SSCM's statement of the following circumstances of the family if s/he has knowledge of them:

- AU composition
- AU income and resources
- the child's deprivation in the home.

Determine financial eligibility using AFDC income and resource limits.

NOTE: If the SSCM does not have knowledge of these circumstances, coordinate efforts with the SSCM to obtain this information from the family.

If AFDC relatedness can be established, proceed to Step 6.

If AFDC relatedness cannot be established, complete a CMD and notify the SSCM on Form 713.

NOTE: Do not complete a CMD for a SSI child found ineligible for IV-E FC.

Step 6 Determine the child's financial eligibility as an AU of one using the IV-E Gross Income Ceiling and the IV-E Standard of Need and the AFDC resource limit. Refer to Section 2840, IV-E Budgeting.

Step 7 Refer the AP(s) to CSE on Form 122, Foster Care Referral Form. Mail the form to the local CSE office.

NOTE: Refer to Section 2850, Special Considerations, for circumstances when a referral is not appropriate.

PROCEDURES (cont.)

Step 8 If the child is IV-E FC eligible, approve IV-E Foster Care and document on the SUCCESS system. Using Form 713, notify the SSCM of the eligibility, including the beginning date of IV-E eligibility.

Assign each foster child an individual case number and case record.

Retain the Form 297 and all documentation in the case record for permanent verification.

If all points of eligibility cannot be established or the child is financially ineligible, deny the IV-E application and complete a CMD.

NOTE: Do not complete a CMD on a SSI child determined ineligible for IV-E FC.

Authorizing Medicaid for Out-of-state IV-E FC Child Residing In Georgia

Follow the steps below to authorize Medicaid for an out-of-state IV-E FC child placed in Georgia when the SSCM initiates the request for Medicaid:

Step 1 Obtain a Form 297 including the signature of the SSCM or foster parent.

Step 2 Establish IV-E FC eligibility by verifying the following:

- The child receives IV-E FC per diem from the state of origin.
- The child is currently residing in Georgia in an approved foster care placement. Verify the date of the move.
- The child is under age 18. The child's DOB on the Medicaid card of the out-of-state origin is sufficient verification.
- Obtain the child's Social Security number. The statement of the SSCM, foster parent, or other reliable source is sufficient verification.

PROCEDURES

Authorizing Medicaid For Out-of-state IV-E FC Child Residing in Georgia (cont.)

Step 3	Approve Medicaid and send the Medicaid card and notification to the foster parent. Send a copy of the notification to the SSCM.
Step 4	Continue Medicaid until the child is no longer IV-E eligible, is no longer living in Georgia or until the SSCM requests case closure.
Step 5	Complete reviews of the child's eligibility for IV-E FC Medicaid in Georgia by completing Step 2 above.

2817 - IV-E ADOPTION ASSISTANCE MEDICAID

POLICY STATEMENT

Adoptive children who are determined eligible for IV-E Adoption Assistance (AA) are eligible to receive IV-E AA Medicaid.

BASIC CONSIDERATIONS

The IV-E AA program provides IV-E funded subsidies to parents adopting children with special needs.

Special Needs

In order for a child to qualify as having special needs, all three of the following criteria must be met.

- The child cannot or should not be returned to the home of his/her parents.

and

- There exists a specific factor or condition which precludes adoptive placement without IV-E Adoption Assistance of Title XIX medical assistance. These factors include, but are not limited to the following:

  - ethnic background
  - age
  - membership in a minority or sibling group
  - presence of a mental condition
  - physical, mental or emotional disability

and

- A reasonable but unsuccessful effort to place the child with appropriate parents without providing Adoption Assistance has been made.

The SSCM determines if the special needs criteria have been met.

A IV-E eligibility determination is required before Social Services can authorize IV-E Adoption Assistance.

The Eligibility Worker (EW) determines eligibility for IV-E.

Once the EW determines that the adoptive child is IV-E eligible, the Office of Adoptions is notified by the SSCM.

BASIC CONSIDERATIONS (cont.)

For IV-E AA, the child does not have to be continually eligible under IV-E standards, but must be determined IV-E eligible at the following times:

- removal from the home
- in the month the adoption petition is initiated

The IV-E eligible child must meet AFDC deprivation criteria both at the time of removal from the home and at the time of adoptive placement.

NOTE: Termination of Parental Rights may be used to meet the deprivation requirement only in the month the adoption petition is initiated.

IV-E eligibility begins at the time of adoptive placement as long as the adoptive assistance agreement is in effect.

A court order must be initiated within six months of removal and contain *contrary to the welfare* language.

If the placement is initiated through a voluntary placement agreement, a judicial determination containing *contrary to the welfare* language must be made within the 180-day limitation of the voluntary placement and a IV-E FC payment must be made during the 180 day period.

A child placed pursuant to a voluntary placement agreement under which a title IV-E maintenance payment is not made is not eligible to receive IV-E Adoption Assistance.

If placement is initiated by a voluntary relinquishment, the State must petition the court within six months of removal. A judicial determination to the effect that remaining in the home would be contrary to the child's welfare must be obtained within the six months time frame.

There are two circumstances under which the nature of a child's removal from his/her home is irrelevant:

- When a child is SSI eligible at the time adoption proceedings are initiated and the State determines the child meets the definition of special needs prior to the finalization of the adoption

BASIC CONSIDERATIONS (cont.)

- In a subsequent adoption when a child received title IV-E adoption assistance in a previous adoption that dissolved or in which the adoptive parents died, if the State determines that the child continues to be a child with special needs

A child who is receiving IV-E AA is eligible for Medicaid in the state in which s/he resides. Refer to PROCEDURES in this Section for instructions on the IV-E determination and Medicaid authorization for a Georgia child placed out of state.

Reviews are not required for IV-E AA, but are required for the related Medicaid Case.

PROCEDURES

Consider the SSCM's written request for an IV-E AA determination as an application for assistance.

Follow the steps below to determine IV-E AA eligibility.

Step 1 Conduct a face-to-face interview with the SSCM to establish AFDC points of eligibility. Have the SSCM sign a Form 297, Application for TANF, Food Stamps or Medical Assistance.

Step 2 Obtain a Form 713, Interagency, Interoffice Referral and Follow-Up, to verify all of the following information:

- the date the petition for custody is filed
- the date the judicial determination is made
- assurance that the *contrary to the welfare* language was obtained within six months of the removal
- the name of the agency or individual to whom the court gives responsibility for placement of the child.

Step 3 Establish the month the child was removed from the home. This is the month in which the petition for custody was filed, the Voluntary Placement Agreement was signed or the voluntary relinquishment was signed.

Step 4 Accept the SSW's statement of the following circumstances of the family if s/he has knowledge of them:

- AU composition
- AU income and resources
- the child's deprivation in the home.

PROCEDURES

Step 4 (cont.) **NOTE:** If the SSCM does not have knowledge of the circumstances, coordinate efforts with the SSCM to obtain this information from the family.

If the child did not live with a specified relative the removal month, determine if s/he lived with a specified relative in any one of the six months prior to the date the petition for custody was filed or the voluntary placement/relinquishment agreement was signed.

Establish AFDC relatedness in the removal home. Determine if the child could have received AFDC in the home in the removal month if the child had been living with the specified relative from whom custody was removed.

If AFDC relatedness can be established, proceed to Step 5.

If eligibility for AFDC cannot be established, notify the SSCM and complete a CMD with the assistance of the SSCM.

Step 5 Determine the child's financial eligibility as an AU of one using IV-E Gross Income Ceiling and the IV-E Standard of Need and the AFDC resource limit. Refer to Section 2840, IV-E Budgeting.

Step 6 For the month of the filing of the adoption petition, establish that the deprivation still exists in the home from which the child was removed according to AFDC criteria.

NOTE: Use the court order terminating parental rights to verify deprivation at this point.

Determine that the child is in financial need as an AU of one based on IV-E Foster Care Standards of Need. Do not consider the adoptive parents' income and resources. See Section 2840, IV-E Budgeting.

PROCEDURES (cont.)

Step 7 Determine the following eligibility criteria for the month the adoption petition is filed:

- that the child is under 18 years of age
- that the child is in financial need as an AU of one based on IV-E Foster Care Standards of Need. Do not consider the adoptive parents' income and resources. See Section 2840, IV-E Budgeting.

Step 8 Notify the SSCM in writing of the child's eligibility for IV-E and attach copies of the eligibility determination.

Refer to Section 2850, Special Considerations, for instructions on authorizing Medicaid for out of State Adoption Assistance children residing in Georgia

2820 - LEGAL STATUS

POLICY STATEMENT

Legal responsibility and care for a child must be given to DFCS or another public agency under contract with Georgia Department of Human Resources before Title IV-E eligibility can be established.

BASIC CONSIDERATIONS

A child must enter care pursuant to a court order or a voluntary placement agreement. The SSCM is responsible for ensuring that the necessary legal proceedings concerning the removal and placement of children in out-of-home care are initiated and carried out in a timely manner, and that the appropriate judicial determinations are obtained. The SSCM must notify the EW that the appropriate judicial language is included in the court order. The EW should accept the statement of SSCM that the correct judicial language is included in the court order. It is not necessary to acquire a copy of the court order.

Court Ordered Removal

There are two types of court orders:

- permanent - issued when parental rights are severed
- temporary - issued for duration of 12 months from the date of removal with one extension of 12 months permitted. If a child remains in DFCS custody beyond this period, it is necessary to file a new deprivation petition.

To establish IV-E eligibility, the initial court order must include a judicial determination that continuation in the home would be *contrary to the welfare* of the child or that placement is in the *best interest* of the child. The SSCM should make every effort to ensure that the initial custody order, (i.e., the order issued as a result of the 72 hour hearing) sanctioning the removal of the child, contains the required language, otherwise the child cannot be IV-E eligible.

If the required language is not in the initial order, the child will never be IV-E eligible (or IV-E reimbursable) at any time during that placement episode.

Affidavits and Nunc Pro Tunc order or orders referencing the judicial court code are not acceptable for meeting the *contrary to the welfare* or *best interest* judicial language requirement. Nunc Pro Tunc orders are court orders that give retroactive effect to a judicial finding included in the order; the purpose of which is to clear up omissions in a previous court order that were inadvertently excluded. The required language must be stated in the initial court order.

BASIC CONSIDERATIONS

Court Ordered Removal (cont.)

There must be a court order within 60 days of the child's removal that contains judicial language to the effect that *reasonable* efforts were made to prevent removal of the child or that reasonable efforts were not required to prevent removal of the child from the home. The child cannot be determined IV-E eligible until reasonable efforts language is obtained. If the reasonable efforts language is not obtained within 60 days of the child's removal, the child is not eligible for IV-E during that placement episode. The SSCM should make every effort to obtain the reasonable efforts language in the initial court order.

Voluntary Placement Agreement

A voluntary placement agreement is a signed written agreement between DFCS and the parent(s) or the legal guardian(s) of the child. It specifies the legal status of the child, and the rights and obligations of the parent(s) or legal guardian(s) and the county DFCS while the child is in out-of-home placement. The agreement is limited to 90 days, with the possibility of one additional 90-day extension. No placement is reimbursable without legal authorization for custody. A VPA or court order must currently be in effect for reimbursement.

Federal law allows IV-E eligibility and reimbursability to continue for 180 days under a voluntary placement agreement without a court order. If the child remains in care under a voluntary placement agreement beyond 180 days without acquiring a court order which states that continued voluntary placement is in the *best interest* of the child, the child will lose IV-E eligibility on the 181st day and for the remainder of the placement episode.

For those children that enter DFCS care and responsibility via a voluntary placement agreement, a judicial determination that reasonable efforts to prevent removal is not required for meeting IV-E eligibility.

Voluntary Relinquishment

Voluntary Relinquishment, also called a voluntary surrender of parental rights, occur when a parent voluntarily signs the child into foster care for the purpose of adoption. The child is surrendered to the Department of Human Resources and the rights and duties of the county DFCS are the same as if parental rights had been terminated in court. The parent loses all parental rights and responsibilities of the child. The parents may be obligated to pay child support until such time an adoption is finalized.

Foster Care: A child in this situation may only be IV-E Foster Care eligible the child had last been living with the parent(s) within six months of the date court proceedings were initiated leading to a judicial determination that included *contrary to the welfare* and *reasonable efforts* language.

Adoption Assistance: An otherwise eligible child who had been living with the parent(s) within six months of the date court proceedings were initiated leading to a judicial determination that included *contrary to the welfare* language will be eligible for IV-E Adoption Assistance. The *reasonable efforts* determination is not required.

NOTE: Voluntary relinquishments or voluntary surrenders are only taken when adoption is a viable plan for the child. Refer to the Social Services Manual for additional information.

2825 - AFDC RELATEDNESS

POLICY STATEMENT

A child must meet AFDC relatedness criteria in order to be IV-E eligible.

BASIC CONSIDERATIONS

The child must have a relationship to the Aid to Families with Dependent Children (AFDC) Program within six months prior to or during the eligibility month. In all references to AFDC relatedness, the eligibility of the child is based on the AFDC program in effect in Georgia's State Plan on July 16, 1996.

The eligibility month is the month of the initiation of court proceedings (i.e., the filing of the complaint or petition) that led to the removal of the child or the date a voluntary placement agreement (VPA) was signed.

A child meets the AFDC relatedness test if one of the following conditions is met:

- The child lived with a specified relative and would have received AFDC in the eligibility month if an AFDC application had been made.

OR

- The child was removed from a home other than a specified relative but lived with a specified relative at some point within six months prior to the eligibility month and would have received AFDC in that home had an application been made.

The criteria which define AFDC eligibility (or potential eligibility) for the removal home for IV-E purposes are:

- age
- living with a specified relative in the removal home
- deprivation
- financial need (income and resources)
- citizenship/alienage

Age

To be IV-E eligible, the child must be under the age of 18. IV-E eligibility always discontinues when the child reaches age 18.

BASIC CONSIDERATIONS (cont.)

Living with a Specified Relative

For a child to meet IV-E eligibility, the child must have lived with a specified relative during the eligibility month, or within six months prior to the eligibility month. The specified relative, with whom the child most recently lived, during the eligibility month or within six months prior to the eligibility month, is considered the relative from whom the child was removed.

Refer to Section 2245, Living with a Specified Relative.

The requirement for living with a specified relative is met if a newborn child is placed in DFCS care and responsibility directly from its birthplace in a hospital.

Identifying the correct specified relative home where the child lived and was considered removed from is critical for two very important reasons:

- it identifies the removal home;
- it determines the AFDC Assistance Unit in determining if the child meets the financial needs criteria.

Removal Home

The SSCM must determine the home from which the child is considered removed. There are two types of removal when determining the removal home: **physical and constructive** removal.

Physical removal occurs when the agency has physically removed the child from the home of a specified relative.

Constructive removal is considered paper removal; when DFCS has obtained custody of the child; but did not physically remove the child from the home of a specified relative but the child lived with a specified relative within six months of the eligibility month.

A child is considered constructively removed on the date of the first judicial order removing custody even temporarily from the appropriate specified relative or the date the VPA is signed.

The specified relative criteria and removal requirement are inter-related. The specified relative with whom the child most recently lived (during the eligibility month), is considered the relative from whom the child was removed; this is considered the **removal home**.

BASIC CONSIDERATIONS

Removal Home (cont.)

There are four types of scenarios for meeting the living with specified relative and removal criteria.

Scenario 1

The child was removed from a specified relative at the time DFCS initiated custody or the date of a signed VPA (eligibility month) and was placed in out-of-home care.

- Removal home is the home of the specified relative from which DFCS removed the child.
- Date of removal is the date DFCS removed the child.

Case example: The child was living with mother at the time the agency initiated custody and removed the child from the mother's home on December 12. The mother's home is the removal home and December 12 is the removal date.

Scenario 2

DFCS *removed the child from a non-specified relative* and the child did live with a specified relative within six months prior to DFCS initiating custody or the date of a signed VPA (eligibility month).

- Removal home is the home of the most recent specified relative where the child resided within six months prior to the eligibility month.
- Date of removal is the date the petition was filed to obtain custody.

Case example: The child had been living with friends for two months preceding the time police detained the child. DFCS initiated custody on May 14 and placed the child in out-of-home care. Prior to living with friends, the child was living with her parents until January 3. She subsequently went to live with grandparents, until March 14. On this date, she went to live with her friends. The *grandparents'* home is the removal home (most recent specified relative the child lived with) and *March 14* is the removal date.

BASIC CONSIDERATIONS

Removal Home (cont.)

Scenario 3

At the time of initiating agency custody, the child was living in the home of a non-parent specified relative but the child lived with a different specified relative within six months of the petition for initiating custody or the date of a signed VPA (eligibility month).

- Removal home is the home of the most recent specified relative, where the child resided within six months prior to the eligibility month.

- Date of removal is the date the petition was filed requesting custody.

Case example: The child had been living with his father until March 22, at which time he went to live with aunt. On April 3, the agency initiated custody of the child, but the agency leaves the child in the aunt's home as a relative placement. The father's home is the removal home and April 3 is the removal date.

Scenario 4

Child has been living with the specified relative for over six months prior to the agency initiating custody. The agency obtains custody of the child and leaves the child in the home of that specified relative but the agency removes the child at a later date within six months after the petition for initiating custody or the date of a signed VPA (eligibility month).

- Removal home is the specified relative home that the child lived in prior to, during, and after the eligibility month at the time the agency physically removed the child (within six months after the eligibility month).

- Date of removal is when the agency physically removed the child.

- If the agency did not remove the child within six months after the eligibility month, the child could not be IV-E eligible until the child re-enters the agency's placement and custody and a new IV-E eligibility determination is conducted.

BASIC CONSIDERATIONS

Removal Home (cont.)

Case Example: Since 1997 the child has been living with a great-grandfather. On January 23, the agency initiated custody of the child but leaves the child in the great-grandfather's home as a relative placement. On May 10, the agency removes the child from the great-grandfather's home and places the child in an uncle's home as a relative placement. The *great-grandfather's home* is the removal home and the date of removal is *May 10*.

If the agency removed the child from the great-grandfather's home after July 23 (after six months from the eligibility month, January 23), the child would not be eligible for IV-E since removal did not occur within six months of the agency initiating custody. This example can also be applied to a parent, for instance, if you were to replace great-grandfather with mother.

Assistance Unit

The Assistance Unit is the grouping of persons from the removal home whose income and resources must be considered in determining if the child meets financial need: income and resources criteria for AFDC relatedness.

If the child was removed from the parent's home, the AFDC AU would include any of the following individuals residing in the home at the time of removal:

- birth or adoptive parents
- child in custody
- Any minor siblings (birth, adoptive or half) of the child in custody.

If the child was removed from the home of a specified relative other than the parent(s), the AFDC AU would include any of the following individuals residing in the home, with the child at the time of removal:

- child in custody
- Any minor siblings (birth, adoptive, or half) of the child in custody, who were living in the removal home at the time of the child's removal.

BASIC CONSIDERATIONS

Assistance Unit (cont.)

Any household member receiving SSI benefits is not counted as a member of the AFDC AU, unless the household member is the child in custody. In addition, the SSI benefits and any other income or resources of the SSI recipient are not counted in determining financial need.

An adoptive sibling to the child, who is receiving adoption assistance, may be excluded from the AFDC AU. (The adoptive sibling's income and resources would be excluded).

If the child in custody and under review is receiving adoption assistance, do not count the child's income and resources when determining financial need, however count the child as a member in the AFDC AU.

Deprivation

In order to meet the AFDC deprivation criteria, the child must have been deprived of the care, guidance or support of one or both parents (married or unmarried), if paternity is established. Deprivation must exist in the eligibility month. Statements from family members, DFCS observation or information from available systems must verify deprivation.

Deprivation results from one of the following situations in the removal home:

- **death**
- **separation**: one of the parents is not living in the same house
- **divorce**: one of the parents is not living in the same house
- **continual absence**: one of the parents is continually absent from the home where the child resides
- **institutionalized/incarcerated**: one of the parents is in an institution or incarcerated, prior to the child's placement

BASIC CONSIDERATIONS

Deprivation (cont.)

- **incapacitated or disabled**: any condition of mind or body which substantially reduces or eliminates the ability of the parent to support or care for the child. The parent must be determined to be disabled or incapacitated for at least 30 days. If the parent is receiving SSI or Social Security disability benefits, Veteran's Disability benefits (100%), Railroad benefits, or Worker's Compensation benefits, the incapacitation requirement is met and verification of benefits shall be included in the record (such as a copy of the award letter, or copy of a check). If these are not available, third party verification by a doctor is required

- **termination of parental rights**: if there has been a termination of parental rights, the child is deprived from the date of the termination of parental rights.

- **unemployment of the principal wage earner**: this condition only applies when both parents are present in the household. The child can be considered to meet deprivation if the principal wage-earning parent is unemployed. The principal wage earning parent is the parent who earned the greater amount in the 24-month period prior to the eligibility month.

Unemployment of the PE is defined as one of the following:

- being out of work for 30 consecutive days

OR

- working fewer than 100 hours in the 30 consecutive calendar days prior to approval

AND

- working fewer than 100 hours in a calendar month after approval.

Financial Need: Resources

If the child was not deprived of the care and support of one or both parents during the eligibility month, there is no eligibility for IV-E.

The maximum value of resources the child's Assistance Unit (AU) can own is $10,000 to meet the resource limit for the financial need criteria.

If the child was living with either or both parents, the resources of all members of the household (i.e., the person who would have made application and those dependents on that person) are considered in the determination of financial need.

BASIC CONSIDERATIONS

Financial Need: Resources (contd.)

If the child was living with a specified relative, other than the parents, only the child's resources and members of the child's standard filing unit are considered in the determination of financial need.

NOTE: If the child is in receipt of SSI in the eligibility month, the child meets financial need criteria for both income and resources.

See Chapter 2300 for treatment of resources.

Financial Need: Income

Income is calculated utilizing countable earned and unearned income of the removal home AU.

Refer to Section 2835 for AFDC Relatedness Budgeting.

If the removal home AU meets the AFDC SON during the eligibility month, pursue IV-E eligibility.

If the removal home AU does not meet the AFDC Standard of Need during the eligibility month, the child is ineligible for IV-E.

See Chapter 2400 for treatment of income.

Citizenship/ Alien Status

The child must be a US citizen or a qualified alien to be IV-E eligible. It is the responsibility of the SSCM to verify citizenship and or alien status of applicants for IV-E benefits.

Refer to Section 2215, Citizenship/Alienage.

NOTE: DFCS may claim IV-E for an otherwise eligible child pending INS verification of alien status. If INS later verifies the child's alien status does not meet Medicaid requirements, DFCS must adjust prior IV-E claims accordingly.

2826 – AFDC DEPRIVATION-UNEMPLOYED PARENT

POLICY STATEMENT

When both parents are in the home, the unemployment of the parent who is the principal earner (PE) deprives a child of parental support.

AFDC-UP is a category of deprivation and not a special type of AFDC. An AFDC-UP AU is subject to all processing requirements of the AFDC program.

BASIC CONSIDERATIONS

For AFDC-UP purposes, unemployment of the PE is defined as one of the following:

- being out of work for 30 consecutive days

OR

- working fewer than 100 hours in the 30 consecutive calendar days prior to approval

AND

- working fewer than 100 hours in a calendar month after approval

Deprivation Requirements

To establish deprivation because of the unemployment of the PE, the PE must meet each of the criteria below:

- be unemployed for at least 30 consecutive calendar days prior to the AFDC-Relatedness budget month
- have a recent connection to the workforce

Parents must live together, but are not required to be married to each other at the time of the budget month.

If the PE does not meet the citizenship/alien status requirement and does not have INS authorization to work, the family is ineligible for AFDC-UP, and the child cannot be considered deprived due to the unemployment of the parent.

If the PE has INS authorization to work, but does not meet the citizenship/alien status requirement, the PE is not included in the AU. However, other family members are potentially eligible for AFDC-UP.

Unemployment compensation benefits (UCB) received by the PE are budgeted uniquely.

A family is not eligible for AFDC-UP if the PE is unemployed because s/he is on strike.

PROCEDURES

Determine who lives in the home and their relationship to each other.

Explore eligibility for AFDC-UP when a blended family applies and one parent is unemployed as follows:

- When the PE is designated and meets the AFDC-UP definition of unemployed, include the parents, the mutual child(ren), and the child(ren) of each parent in one AU.
- If the AU does not meet the AFDC-UP deprivation requirements, deny AFDC-UP and explore the eligibility of the child in other AU compositions.

Determine eligibility using the steps on the following pages.

Step 1 Determine the Principal Earner

Determine the Principal Earner. The Principal Earner (PE) is the parent with the greater earnings in the two years prior to the application month.

Accept the AU's statement to establish which parent had the greater earnings unless the information provided conflicts with other information available to the agency.

Determine the PE at application following the guidelines in Chart 2826.1

Chart 2826.1 Determining the PE at Application

IF AT APPLICATION	THEN
Both parents have earned income in the 24 months preceding the application month	The parent with the higher earnings in the 24 months is the PE
The earnings of each parent are equal in the 24 months prior to the month of application	The parent with the higher earnings in the most recent six months is the PE.

Step 2 Determine if the PE meets unemployment criteria

Use Chart 2826.2 to determine if the PE meets the unemployment status at the time of application.

Chart 2826.2 Establishing Unemployment Status

IF THE PE	THEN
Is not working at the time of application **AND** Has been unemployed for 30 consecutive days	The unemployment criterion is met on the date of application.
Is employed at the time of application **BUT** Worked fewer than 100 hours in the 30 consecutive days prior to the application date	The unemployment criterion is met on the day of application.

Step 3
Establish if the PE has a recent connection to the workforce

Use chart 2826.3 to determine recent connection to the work force.

At the point the PE meets any one of the requirements, recent connection to the work force is met.

Determine whether the requirement for recent connection is met in the order listed in the chart.

Chart 2826.3 Recent Connection to the Work Force

IF THE PE	THEN
Currently receives UCB	A recent connection to the work force is met. Verify with Clearinghouse or UCB check stub.
Received UCB within one year prior to the date of application (including the application month and the 12 prior calendar months)	A recent connection to the work force is met. Verify with Clearinghouse or UCB check stub.
Would have been eligible to receive UCB in the year prior to the application month had s/he applied	A recent connection to the work force is met. Verify with Clearinghouse

NOTE: No more than four quarters of education/training can be applied toward the six required quarters of work. A maximum of four quarters of education/training may be applied in a lifetime.

Step 4
Determine if the PE has refused a bona fide offer of employment
OR
failed to apply and, if eligible, accept UCB

Determine if the PE failed to accept an offer of employment as training for employment within the 30 consecutive days prior to approval.

If the PE has refused such an offer without good cause, deprivation cannot be met.

Accept the SSCM's statement regarding the offer or acceptance of a bona fide offer of employment unless the agency has information which conflicts with the statement.

Step 5
Determine Eligibility based on Financial criteria

Determine the AU's eligibility taking the following into account:

Apply all normal budgeting procedures with the exception of the budgeting of UCB income. Refer to Section 2835, AFDC Relatedness Budgeting.

Retroactive UCB payments are not treated as a lump sum in AFDC-UP. Budget retroactive UCB payments in the month received.

2830 - AFDC DEDUCTIONS

POLICY STATEMENT	Deductions are applied to the AU's income to determine IV-E financial eligibility.
BASIC CONSIDERATIONS	A $50.00 deduction is applied to child support income according to the following criteria: • prior to the gross income ceiling (GIC) test • to the AU's total child support income whether received via CSE or direct from the non-custodial parent (NCP) • whether the child support is reported untimely or timely. Deductions are applied to earned income according to the following criteria: • after the GIC test • to the earned income of each employed individual • only to income that is reported. Employed individuals include the following: • employed AFDC AU members • sanctioned individuals whose earnings are included in the AFDC budget. Earned income deductions include the following: • $90 standard work expense • $30 earned income deduction • 1/3 of the remaining income • dependent care expenses. Do not apply the above listed deductions to the income of individuals whose income is deemed to an AU through the responsibility budgeting process. The deductions allowed in responsibility and deeming budgeting are unique. Refer to Chapter 2650, Family Medicaid Budgeting. Refer to Section 2655 for instructions on how to apply the deductions.

2835 - AFDC RELATEDNESS BUDGETING

POLICY STATEMENT

AFDC budgets are completed when determining eligibility under IV-E Foster Care or IV-E Adoption Assistance Medicaid.

BASIC CONSIDERATIONS

This is the first of two budgets that must be worked to determine IV-E eligibility.

The AFDC Budget is based on the circumstances in the home from which the child was removed.

The Gross Income Ceiling (GIC) test is used to determine financial eligibility based on the AU's gross countable income.

The Standard of Need (SON) test is used to determine financial eligibility based on the AU's net countable income.

Refer to Chart 2835.1 for GIC and SON limits.

Chart 2835.1 - AFDC Income Standards

Number in AU	Gross Income Ceiling	Standard of Need
1	435	235
2	659	356
3	784	424
4	925	500
5	1060	573
6	1149	621
7	1243	672
8	1319	713
9	1389	751
10	1487	804
11+	1591	860
For each additional Member	+44	+24

BASIC CONSIDERATIONS (cont.)

An individual's income and resources are not considered in two separate AFDC budgets simultaneously.

The resource limit for AFDC relatedness is $10,000.00. Refer to Chapter 2300 for treatment of resources.

All countable income and resources of the AU members are considered in determining financial eligibility.

The countable income of the following non-AU members are considered in determining financial eligibility:

- ineligible parents
- stepparents
- parents of a minor caretaker
- spouses of married minors
- IPV disqualified individuals
- sanctioned SFU individuals.

Employed individuals include the following:

- employed AFDC AU members
- sanctioned SFU individuals whose earnings are included in the AFDC budget.

PROCEDURES

A SSI recipient's income and resources are not considered in determining AFDC eligibility. However, any income given to the AFDC AU by a recipient of SSI is treated as a contribution.

A responsibility budget is completed in the following situations:

- To determine whether a non-parent relative can be included in the AU as caretaker.
- To determine how much of the income of a stepparent or the parent(s) of a minor caretaker to include in the AFDC budget.
- To determine how much income an AFDC eligible adult can allocate to meet the needs of his/her AFDC ineligible spouse and/or child.

Gross Countable Income

Gross countable income is the AU's income after subtracting the following:

- the $50 child support deduction
- allocated income
- the earnings of an AFDC child (see PROCEDURES in this section)
- any other income excluded by law (refer to Section 2400, Income)
- UCB received by the PE in an AFDC-UP AU.

NOTE: Gross countable income includes income deemed from a responsibility budget and earnings from self-employment after subtracting the cost of doing business.

Gross countable income is used in completing the GIC test. Refer to Section 2400, Income, for types of countable income.

Net Countable Income

Net countable income is the AU's income after allowing all deductions (refer to Section 2830, AFDC Deductions). Net countable income is applied to the SON to determine eligibility.

PROCEDURES (cont.)

Earnings of an AFDC Child

Exclude an AFDC child's earnings from gross countable income for up to six months per calendar year if the child is in school at least equal to the amount of time worked according to the following:

- Compare full-time school attendance to full-time work, etc., to determine in school at least equal status.
- After six months of the exclusion, include the earnings as income when completing the GIC test.
- If the AU is eligible based on the GIC test, exclude the child's earnings from the remainder of the budgeting process.

Determining Financial Eligibility

Follow the steps below to establish the AU's financial eligibility for AFDC.

Step 1 Determine the members of the AU (refer to Section 2610, LIM Assistance Units).

Step 2 Identify non-AU members whose income and resources are considered in determining financial eligibility and benefit level.

Step 3 Determine the countable resources, income and expenses of the AU members and those identified in Step 2.

Step 4 Verify all resources, income and expenses as required.

Step 5 Determine that the AU has resources less than or equal to the AFDC relatedness resource limit ($10,000.00).

Step 6 Complete an AFDC budget to determine AFDC financial eligibility.

PROCEDURES (cont.)

AFDC Budget Follow the steps below to complete an AFDC budget.

Step 1 Complete the GIC test by comparing the gross countable income of the AU to the gross income ceiling (GIC) for the AU size.

If the gross countable income is equal to or less than the GIC, follow proceed to Step 2.

If the gross countable income is greater than the GIC, the child is not IV-E eligible. Notify the SSCM. Complete a Continuing Medicaid Determination (CMD).

Step 2 Determine if there are employed individuals in the AU.

If there is an employed individual proceed to Step 3.

If there are no employed individuals, proceed to Step 4.

Step 3 Complete a SON trial budget to determine eligibility for the $30 plus 1/3 deduction.

- Subtract the $90 standard work expense from the gross earned income of each employed individual.
- Subtract dependent care not to exceed the maximum from the earned income of each employed individual who incurs and pays this expense.
- Add the unearned income of all individuals whose income is considered.
- Compare the total net income to the SON for the AU size.

If the total net income is less than the SON proceed to step 4.

If the total net income is greater than or equal to the SON, the child is not IV-E eligible. Notify the SSCM. Complete a CMD.

PROCEDURES (cont.)

Step 4 Determine the AU's income deficit.

- Apply all applicable earned income deductions to the gross countable earned income of each employed individual to determine the net earned income.
- Add the unearned income of all individuals whose income is considered, including any deemed income, to the net earned income to determine the net countable income.
- Subtract any allocated income.
- Deduct the net countable income from the SON.

If the net countable income is less than the SON (there is a deficit), AFDC relatedness (financial need) for the child is established.

If the net countable income is greater than or equal to the SON, AFDC relatedness (financial need) for the child is not established and the child is not eligible for IV-E. Complete a CMD.

NOTE: For complicated budgeting situations, refer to the Economic Support Services Manual, in effect July 1996.

2840 - IV-E BUDGETING

POLICY STATEMENT	IV-E Budgeting procedures are used as the final financial eligibility step when determining IV-E Foster Care or IV-E Adoption Assistance (AA) Medicaid eligibility.
BASIC CONSIDERATIONS	This is the second of two budgets that must be worked in establishing IV-E eligibility. The AU size used in IV-E budgeting is always one, the child in placement. A unique Gross Income Ceiling and Standard of Need are used for IV-E financial determinations. AFDC policy is used in determining gross and net countable income.
PROCEDURES **IV-E Budget**	Follow the steps below to determine the final financial eligibility for IV-E child.
Step 1	Apply all gross countable income to the IV-E child to the IV-E Gross Income Ceiling (GIC) Test. **NOTE:** Exclude SSI benefits received by an IV-E child in determining eligibility. Allow the $50.00 child support disregard in determining the child's eligibility for IV-E. When siblings or half siblings receive child support from the same absent parent, each child is entitled to the $50.00 child support disregard in his/her own AU.
Step 2	If the gross income is less than the IV-E GIC, continue with the IV-E budgeting process. If the gross income is equal to or greater than the IV-E GIC, complete a Continuing Medicaid Determination (CMD). **NOTE:** Do not complete a CMD for a SSI child found ineligible for IV-E.

PROCEDURES (contd.)

Step 3 Subtract all AFDC deductions from the gross countable income.

Step 4 Compare the net countable income (after allowing deductions) to the IV-E Standard of Need (SON).

If the net income is less than the SON, approve the child for IV-E Foster Care or Adoption Assistance. Report the net countable earned income to the SSW.

If the net income is greater than or equal to the SON, complete a CMD. Report eligibility determination to the SSW.

NOTE: Do not complete a CMD for a SSI child found ineligible for IV-E.

Use this chart for determining IV-E Gross Income Ceiling Test and Standard of Need.

STANDARD OF NEED (SON)	**Child's Age**	**Daily Rate X 30**	**SON**
	Birth to 5	$12.75 X 30 =	$382.50
	6 to 12	$13.50 X 30 =	$405.00
	13 and older	$14.25 X 30 =	$427.50

GROSS INCOME CEILING (185% of SON)	**Child's Age**	**GIC**
	Birth to 5	$707.63
	6 to 12	$749.25
	13 and older	$790.88

2845– SSI ELIGIBLE CHILD

POLICY STATEMENT	SSI benefits do not effect a child's IV-E eligibility; a child receiving SSI should always be IV-E eligible if the child meets all the IV-E eligibility criteria.
BASIC CONSIDERATIONS	SSI income is exempt (not counted) in determining if the child meets the financial need requirement for AFDC relatedness. If the child receives SSI in the eligibility month, the child meets AFDC relatedness financial need criteria for both income and resources. As of February 4, 1994, federal policy has allowed the concurrent receipt of SSI and IV-E foster care reimbursement benefits. The SSCM and Eligibility Specialist should continue to aggressively determine IV-E reimbursability for all children, including those receiving or eligible to receive SSI benefits. When a child is IV-E reimbursable, the SSCM must make a decision on whether to continue the child's SSI benefits to cover board and care costs or cover the board and care costs under IV-E. It is not in the child's best interest to lose SSI income while in out-of-home care if it appears the child may be returning home soon, due to the need to have SSI income available upon return home. The cost of care for a child receiving SSI should not be made IV-E reimbursable unless the monthly *federal financial participation (FFP)* amount for IV-E reimbursement of the placement cost for that child exceed the SSI monthly payment. This is because the SSI payment is reduced dollar for dollar by the amount of any Federal Title IV-E reimbursement payments for board and care. In other words, at the point the cost of care multiplied by the FFP amount (the federal Medicaid percentage) is more than the SSI amount, the FFP amount should be considered. SSI is a set amount of federal funds. This amount is adjusted every January. Title IV-E federal funds are not limited, and will reimburse allowable costs. Guidelines to follow when considering a child in receipt of SSI: • A child who is eligible for SSI and IV-E reimbursability should continue to receive the SSI check if the SSI payments are more than the IV-E reimbursable FFP for the foster care per diem. The child will be IV-E *eligible*, but not IV-E *reimbursable* for covering the cost of board and care.

BASIC CONSIDERATIONS (contd.)

- The cost of care for a child who is receiving SSI and meets all IV-E reimbursable criteria should be made IV-E reimbursable if the federal IV-E reimbursement for the foster care per diem is more than the SSI payment. In this situation the SSCM is responsible for notifying Social Security Administration (SSA) that the child is receiving an IV-E per diem, including the amount and the effective date. The child's SSI check would be suspended as required by the dollar for dollar rule, and there would be no concurrent receipt of two federal funding sources.

  NOTE: The FFP and the SSI payments change annually.

Programmatic reasons not to discontinue a child's SSI benefits:

- if the child is expected to be in out-of-home care a short period of time (i.e., 60 days);
- the child is in the adoption process;
- the child is approaching age 18 or is in an independent program.

2850 - SPECIAL CONSIDERATIONS

CHILD SUPPORT ENFORCEMENT (CSE) REFERRALS

The parents of a IV-E FC child are referred to CSE, unless one of the following criteria is met:

- The child is in the permanent custody of DHR.
- The child is in a finalized adoptive placement and receives Adoption Assistance from Georgia
- The child has returned home at the time the eligibility determination is completed.
- The parent is unknown.
- Good Cause not to refer exists and is supported by a written statement signed by the County Director or the Social Services County Program Director.

  NOTE: The SSCM is responsible for obtaining and providing to the Eligibility Specialist written approval of good cause from the County Director/County Program Director. Retain the documentation in the Eligibility record for audit purposes.

MINOR PARENT AND CHILD IN CARE

The Title IV-E program allows a state to claim IV-E reimbursement for the costs of an infant living in the same placement as its minor parent. (Note: DFCS custody of the child is not necessary in this situation). If the minor parent has been determined IV-E eligible and reimbursable, the added cost of care for the infant living in the same placement can be reimbursed through the mother's Title IV-E status. The infant does not have an IV-E status since there is not a separate judicial removal or custody into foster care. In order to claim reimbursement, the cost of care for both the minor parent and the child must be contained in one payment to the substitute care provider, and the child's cost of care is assigned to the mother's cost of care.

If the child is removed from the minor parent and placed in a separate substitute care placement, the infant would be determined Title IV-E eligible and reimbursable. The child's Title IV-E eligibility would be like that of any child being removed from his/her parent.

JOINT DFCS AND DJJ CUSTODY

A child may be in the joint custody of DFCS and the Department of Juvenile Justice (DJJ).

If DFCS has placement authority, see Section 2810 for application processing procedures.

If DJJ has placement authority, see Section 2812 for application processing procedures.

NOTE: The child cannot be IV-E reimbursable while placed in a detention facility.

AUTHORIZING MEDICAID FOR AN OUT OF STATE AA CHILD RESIDING IN GEORGIA

Medicaid coverage for a IV-E or State AA child is available in the state in which the child resides.

The IV-E or State AA per diem payments remain the responsibility of the state of origin, but Medicaid coverage is the responsibility of the state of residence.

Medicaid covered services for the AA child are based on the coverage available in the state of residence, not the state of origin.

Follow the steps below to activate Medicaid for an out of state AA child residing in Georgia.

Step 1 Verify that the child is a recipient of IV-E or State AA. Use the current certified copy of the approved adoption assistance agreement from the state of origin. Make a copy of the agreement for the Georgia file.

NOTE: The adoptive parents should be able to provide this agreement or other documents showing IV-E or State AA eligibility in the other state.

Step 2 Establish that the child is under age 18.

NOTE: The child's birth date on his previous state's Medicaid card is sufficient or the written statement from the other state as to the child's date of birth is acceptable.

Step 3 Establish that the child resides in Georgia and document the date the child moved to Georgia.

Step 4 Obtain the child's Social Security number.

NOTE: The information may be obtained from the parents or the state of origin.

AUTHORIZING MEDICAID FOR AN OUT OF STATE AA CHILD (cont.)

Step 5

Send a memorandum to the Office of Adoptions with the following information:

- the name, birth date, address and ID number of the child
- the month the child became a resident of Georgia regardless of the date of the application
- the adoptive parent(s)' name(s), race and sex
- the state in which the VI-E or State AA agreement was initiated.

In the memorandum, identify the child as IV-E or State AA eligible.

Send the memorandum to the following address:

The Office of Adoptions
2 Peachtree Street, NW
8th Floor
Atlanta, Georgia 30303

NOTE: Medicaid eligibility in Georgia begins the first month of Georgia residency, regardless of Medicaid status in the state of origin.

MEDICAID ELIGIBILITY FOR A GEORGIA AA CHILD WHO MOVES OUT OF STATE

When a IV-E or State AA child from Georgia moves to another state, the child's Georgia Medicaid is terminated effective the month after the move.

Use the following chart to determine financial eligibility and appropriate class of assistance for children in IV-E foster care.

Chart 2850.1 Special Situations in IV-E

IF	THEN determine eligibility for the child in the following order:	AND determine financial eligibility as follows
an out-of state IV-E FC child is placed in Georgia	The other state is responsible for the IV-E FC determination. Refer to "Authorizing Medicaid for an Out-of-State IV-E FC Child Residing in Georgia. (Section 2815)	NA. The other state is responsible for the determination.
a Georgia IV-E FC child is placed out-of-state	IV-E FC. Georgia is responsible for initial and ongoing determinations and provides verification of this eligibility to GA SSCM who forwards the information to the state of current residence. **NOTE:** Process as any other IV-E FC case. Because the Georgia Medicaid card cannot be suppressed, have it sent to the SSCM for destruction.	Initial eligibility requires an AFDC determination for AU from which the child is removed. Final financial determination is child only.
a child enters FC under a voluntary placement	1. IV-E FC. If eligible, this eligibility is for 180 days only unless a judicial determination is obtained within this time frame that states that continued placement is in the best interest of the child. If the child remains in care under a voluntary placement agreement beyond 180 days without acquiring a court order which states that continued placement is in the best interest of the child, the child would lose IV-E eligibility on the 181st day and for the remainder of the placement episode. 2. RSM or CW-FC 3. MN	1. Initial eligibility requires an AFDC determination for the AU from which the child is removed. Final financial determination uses child only as an AU of one. 2. Budget the child as an AU of one. 3. Budget the child as an AU of one.

Chart 2850.1 Special Situations in IV-E (cont.)

IF	THEN determine eligibility for the child in the following order:	AND determine financial eligibility as follows
a child enters FC under a voluntary relinquishment of parental rights	1. IV-E FC. A child in a pre-adoptive home due to voluntary relinquishment is rarely IV-E eligible. See Section 2820, Legal Status for the exception	1. Initial eligibility requires an AFDC determination for the AU from which the child is removed. Final financial determination uses child only as an AU of one.
	2. RSM or CW-FC	2. Budget the child as an AU of one.
	3. MN	3. Budget the child as an AU of one.
IV-E FC child is returned to parents on a trial visit	IV-E FC reimbursability is terminated but IV-E eligibility is retained during a trial visit of less than six months, or longer if the court orders a longer home visit. A new application must be filed for IV-E FC when the child returns to a foster care placement but AFDC eligibility does not have to be reestablished. If the trial home visit extends beyond six months or the court authorized time period, and the child is subsequently returned to foster care, the placement must be considered a new placement and requires a new (initial) determination of all eligibility factors. The judicial determinations regarding contrary to the welfare and reasonable efforts to prevent removal are required.	Budget the child as an AU of one Initial eligibility requires an AFDC determination for AU from which the child is removed. Final financial determination uses child only as an AU of one.

Chart 2850.1 Special Situations in IV-E (cont.)		
IF	**THEN determine eligibility for the child in the following order:**	**AND determine financial eligibility as follows**
IV-E child runs away	IV-E FC reimbursability is terminated but IV-E eligibility is retained if the child returns within six months and the court order is still in effect. A new application must be filed for IV-E FC when the child returns to a FC placement but AFDC eligibility does not have to be reestablished. (All other eligibility must be met.) If the child is on runaway status longer than six months or the court order expires and the child subsequently returns to foster care, the placement must be considered a new placement, and requires a new (initial) determination of all eligibility factors. The judicial determinations regarding contrary to the welfare and reasonable efforts to prevent removal are required.	Budget the child as an AU of one. Initial eligibility requires an AFDC determination for the AU from which the child is removed. Final financial determination uses the child only as an AU of one.
IV-E child's adoptive placement is disrupted or dissolves **Disruption**: The removal of a child(ren) from an adoptive placement after the signing of the placement agreement but before legal finalization. **Dissolution:** The termination/voluntary surrender of parental rights by the adoptive parent(s) of a child(ren) on whom the adoption has been legally finalized.	IV-E FC reimbursability is terminated but IV-E eligibility is retained. A new application must be filed for IV-E FC but AFDC relatedness does not have to be established. (All other eligibility criteria must be met.)	Budget the child as an AU of one

Chart 2850.1 Special Situations in IV-E (cont.)		
IF	**THEN determine eligibility for the child in the following order:**	**AND determine financial eligibility as follows**
The mother of a child was AFDC eligible, the child was placed for adoption at birth, the adoptive placement fails and the child is placed in FC	1. IV-E eligibility if the child is placed in FC within six months of the initial adoptive placement and a court order was obtained with the appropriate judicial language during the six months. 2. RSM 3. CW-FC	1. Initial eligibility requires an AFDC determination for the AU (birth mother) from whom the child was removed. Final financial determination uses child only as an AU of one. 2. Budget the child as an AU of one. 3. Budget the child as an AU of one.
IV-E FC child has a child living with him/her and assistance is requested for the minor parent's child.	1. IV-E FC minor parent can apply for LIM for his/her child only. 2. Newborn if eligible 3. RSM or CW-FC	1. Budget the minor's child as an AU of one and include any contributions from the mother. 2. N/A 3. Child and parent are included in the BG. The parent's per diem must be included.

Chart 2850.1 Special Situations in IV-E (cont.)		
IF	**THEN determine eligibility for the child In the following order:**	**AND determine financial eligibility as follows**
IV-E FC child has a child living in a separate FC placement	1. IV-E FC eligibility if all criteria is met. 2. RSM or CW-FC	1. Initial eligibility requires an AFDC determination for the AU from which minor parent's child is removed. Final financial determination uses minor parent's child only as an AU of one. 2. Budget the minor parent's child as an AU of one.

2860 - IV-E REIMBURSABILITY

POLICY STATEMENT	The determination that a child is IV-E reimbursable qualifies the State to obtain federal IV-E funding for maintenance costs (board and care) associated with the child.
BASIC CONSIDERATIONS	Title IV-E reimbursability may fluctuate from month to month. A child may lose and regain IV-E reimbursability depending on changes in deprivation, the child's income and resources, the circumstance in the placement, or in obtaining the required judicial determinations while the child remains in DFCS custody or the custody of another public agency under contract with Georgia Department of Human Resources. The loss of IV-E reimbursability does not deprive the child of future IV-E reimbursability once the reimbursability criteria are met again. The following criteria must be met for a child to be IV-E reimbursable: • child is under age 18 • deprivation exists in the removal home • child meets financial need criteria (based on only the child's income and resources once initial IV-E eligibility has been established) • child resides in a IV-E reimbursable placement • child is in the custody of DFCS or another public agency under contract with Georgia Department of Human Resources • there is a judicial determination of reasonable efforts to finalize the child's permanency plan within 12 months of the child's removal and at least every 12 months thereafter while the child is in foster care. • for those children in DFCS care under a VPA, a best interest or contrary to the welfare judicial determination must be obtained from a court within 180 days; otherwise the child is IV-E reimbursable for the first 180 days only.

BASIC CONSIDERATIONS (contd.)

If any one of the IV-E reimbursable criteria are not met in a month, IV-E reimbursability is lost as of the first of the month.

EXCEPTION: A change in placement affects the reimbursability as of the date of change.

IV-E Reimbursable Placement

Federal regulations, effective March 27, 2000 require that a foster family home (relative or non-relative) and a residential child care facility must meet the standards for full approval as a foster family or residential child care facility. *Temporary approvals of foster families or residential child care facilities do not meet the full approval/licensure requirement.*

There are four types of providers which meet the legal definition of a IV-E reimbursable facility:

- a licensed or approved foster family home
- a licensed or approved relative foster home
- a private, non-profit or for profit group home or child care facility licensed by the state; and
- a public (government operated) non-medical child group home or child care facility licensed for no more than 25 children.

BASIC CONSIDERATIONS

Non-IV-E Reimbursable Placements

In Non-IV-E reimbursable placements, the child is neither reimbursable nor eligible. Non-IV-E reimbursable placements include the following:

- juvenile detention centers (public or private)
- youth forestry camps (YFC) (secure and non-secure)
- youth development centers (YDC) and other public or private facilities (secure and non-secure) that are operated primarily for the detention of delinquent children, which must be (a) physically restricting and (b) likely to be non-operational without a population of children adjudicated delinquent (i.e., hardware secure, locked facilities)
- medical facilities.

If a child enters a reimbursable foster care placement for part of a month but is subsequently moved to a non-reimbursable facility for part of the same month, the child's cost of care is not reimbursable beginning on the date of placement in the non-reimbursable placement. The child is not IV-E reimbursable until entering a reimbursable placement.

2870 - IV-E REDETERMINATIONS

POLICY STATEMENT

Medicaid eligibility is redetermined every 6 months. Reimbursability is reviewed at the six-month Medicaid redetermination for each of the past six months. The child's reimbursability for the next six months is also established. Accounting adjustments (re-rates) are made based on this review.

BASIC CONSIDERATIONS

IV-E reimbursement may fluctuate from month to month. A child may lose and regain IV-E reimbursement, depending upon changes in deprivation in the removal home, the child's income and resources, the circumstances of the placement, or in obtaining the required judicial language while the child remains in DFCS custody. The loss of IV-E reimbursement in one month does not preclude the child's IV-E reimbursement in subsequent months.

Upon redetermination, a child must meet *all* of the IV-E criteria defined below to be determined IV-E reimbursable.

The child must continue to be IV-E eligible, otherwise the child cannot be IV-E reimbursable. IV-E eligibility is determined on a one-time basis at the time the child initially entered the care and responsibility of DFCS, based on the child's situation and the information provided at that time. Once the child is determined IV-E eligible, the child continues to be eligible unless one of the circumstances specified in the *Ineligibility Factors* section exists. Once a child loses IV-E eligibility, s/he cannot be IV-E eligible or reimbursable during the current placement episode. Refer to Section 2880, Ineligibility for IV-E.

Financial Need: Resources

Once a child meets IV-E eligibility, only the resources of the child are considered in determining if the child continues to meet financial need for ongoing IV-E reimbursement. A child's resources may not exceed $10,000. For the month(s) a child's countable resources exceed $10,000, the child is not IV-E reimbursable. The child may become IV-E reimbursable once the child's resources no longer exceed $10,000 if all other criteria are met.

Financial Need: Income

Income is no longer compared to the AFDC Standard of Need as it is for initial IV-E eligibility determination. The child's income cannot exceed 185% of the foster care rate. *This is the only standard to which income is compared in determining if the child meets ongoing IV-E reimbursement.* See Section 2840, IV-E Budgeting.

PROCEDURES

Complete periodic reviews by using the following procedures:

Step 1 Interview the SSCM

Step 2 Complete all necessary forms

Refer to Family Medicaid Reviews, Section 2710.

Step 3 Determine that the court order is valid or has been renewed without interruption, and that a judicial determination that reasonable efforts were made to finalize the permanency plan has been obtained through SSCM statement.

Step 4 Determine that deprivation still exists in the home from which the child was removed. Accept the SSCM's statement.

NOTE: If the home has been dissolved or the whereabouts of the specified relative is unknown, deprivation still exists.

Step 5 Establish current financial eligibility using IV-E Budgeting standards.

Step 6 Determine that the child remains in an approved placement.

Step 7 Process the review in the system and notify the SSCM.

2880 - INELIGIBILITY FOR IV-E

POLICY STATEMENT	There are circumstances that cause a child to no longer be IV-E eligible. Once a child loses IV-E eligibility, s/he cannot be IV-E eligible or reimbursable during the current placement episode.
BASIC CONSIDERATIONS	A child will lose IV-E eligibility if one of the following circumstances exists: • the child no longer meets age requirement. • DFCS has terminated custody. • the child is in DFCS care and responsibility under a voluntary placement agreement (VPA) and a custody order with a best interest/contrary to the welfare statement was not obtained within 180 days of the signed VPA. • Judicial determination with *reasonable efforts to prevent removal* or *reasonable efforts were not required* language is not obtained within 60 days of the child's removal. • the child is on a trial home visit or run away status beyond six months or the trial home visit exceeds the time frame authorized by the court. The court may return a child who has been in out-of-home care back into the removal home for a *trial visit* for an unspecified period of time. If the trial visit, with continuous DFCS custody, is six months or less and the child returns to out-of-home care, the child retains IV-E eligibility. If the court authorizes a time frame longer than six months, the child can retain IV-E eligibility, provided the child returns to out-of-home care at the end of the specified time frame.

BASIC CONSIDERATIONS (contd.)

Special eligibility considerations exist when a child returns home on a trial visit.

- A child is never payment eligible when living in the home of a parent.
- If the six-month time frame or the court's authorized time frame is exceeded, the child loses IV-E eligibility. If the child subsequently re-enters care, the placement is considered a new placement episode.
- A new initial custody order must be obtained pertaining to the current situation (removal) including a judicial determination of contrary to the welfare/best interest and reasonable efforts. A new IV-E eligibility determination must be made based on the child's eligibility in the home from which s/he was subsequently removed.
- If a child re-enters care, the SSCM is responsible for informing the FCE Specialist if the child's stay at home was within the above time frames.
- The same IV-E principles for trial home visits apply to IV-E eligible children on run away status.

2890 - CHILD WELFARE FOSTER CARE MEDICAID

POLICY STATEMENT

Child Welfare Foster Care (CWFC) Medicaid provides coverage to children in placement for whom DFCS has partial or total responsibility, but who have been determined ineligible for IV-E Foster Care. Eligibility includes CWFC children ages 18 to 21 years if CWFC per diem payments continue to be made on their behalf.

BASIC CONSIDERATIONS

Eligibility for any non IV-E foster care child can be determined under RSM rather than CWFC Medicaid. If eligibility is determined under RSM, all siblings in the same foster home must be included in the same RSM AU. If the child is financially ineligible for RSM and CWFC, provide the SSCM with a PeachCare for Kids application and PeachCare for Kids program information. If the child is financially ineligible for PeachCare for Kids, process the application as Family Medicaid Medically Needy.

NOTE: If a child in placement is approved under RSM rather than CWFC Medicaid, the eligibility worker (EW) must notify the Division of Medical Assistance (DMA) of the child's foster care status in order to exempt the child from mandatory Georgia Better Health Care (GBHC) participation.

A child committed to the Department of Juvenile Justice or an agency of the Department of Human Resources other than DFCS is ineligible for CWFC. Eligibility may be determined under RSM, or if financially ineligible, PeachCare for Kids. If the child is financially ineligible for PeachCare for Kids, eligibility may be determined under Family Medicaid Medically Needy.

Basic Eligibility Criteria

The DFCS Social Services Case Manager (SSCM) authorizes CWFC per diem to be paid from state funds.

CWFC children must meet the following Basic Eligibility Criteria:

- age
- application for other benefits
- citizenship/alienage
- enumeration
- third party resources

BASIC CONSIDERATIONS

Basic Eligibility Criteria (contd.)

The parents of a CWFC Medicaid child are referred to Child Support Enforcement unless Good Cause is established. Good Cause must be supported by a written statement signed by the county DFCS director.

Refer to Chapter 2200, Basic Eligibility Criteria.

Financial Eligibility Criteria

CWFC children must meet LIM income and resource limits.

Refer to Section 2650, Family Medicaid Budgeting and Appendix A2, Financial Limits for Family Medicaid.

The child's eligibility for CWFC Medicaid is determined according to the child's circumstances in foster care. Income and resources of the parent(s) or other specified relative(s) are not considered.

Other Considerations

CWFC children must be under partial or total financial responsibility of DFCS.

CWFC children must be placed in an approved foster care home or licensed child care facility.

Refer to Section 2066, Placement Outside the Home.

CWFC Medicaid eligibility continues through the month in which the CWFC child reaches age 21, if CWFC per diem payment continue to be made and all financial and non-financial requirements continue to be met.

Eligibility for CWFC Medicaid is not determined for the month of placement if the child received Medicaid under another COA during that month. The SSCM can, however, authorize per diem payments for the initial month of foster care placements.

A CWFC child is excluded from any LIM AU, even if the child is a minor parent.

BASIC CONSIDERATIONS

Other Considerations (contd.)

Each foster child is assigned an individual case number and case record, independent of siblings or half-siblings that may be in the same foster care placement.

Applications for CWFC are initiated and processed in the county of legal residence where the court order or voluntary placement agreement was signed.

Any written request for CWFC Medicaid by a SSCM on behalf of a child is considered an application for Medicaid.

PROCEDURES

Screen the foster child for IV-E eligibility. Refer to Section 2815, IV-E Foster Care Medicaid.

If the foster child is **NOT** IV-E eligible, determine Medicaid eligibility under RSM or proceed with the CWFC determination.

Follow the steps below to determine Medicaid eligibility under CWFC.

Step 1 Conduct a face-to-face interview with the SSCM upon receipt of the Medicaid application or written request for CWFC.

Step 2 Determine eligibility of the foster child under all LIM basic eligibility criteria except living with a specified relative.

Step 3 Obtain a statement from the SSCM either verbally or in writing that the child is in an approved family home or a licensed child care facility.

Step 4

Determine all income and resources of the child and complete the budgeting process using the LIM income and resource limits. Use deductions, if applicable. Refer to Section 2655, Family Medicaid Deductions.

PROCEDURES (contd.)

Step 5 If the child meets all requirements in Steps 2 through 4, authorize CWFC Medicaid and notify the SSCM and DMA. Include in the notification the beginning date of Medicaid eligibility and the Medicaid recipient number.

NOTE: Continue Medicaid eligibility through the month in which the CWFC child reaches age 21, as long as CWFC per diem payments continue to be made and the child continues to meet all CWFC financial and non-financial requirements.

If the child is determined ineligible for CWFC, complete a CMD prior to termination of Medicaid.

Step 6 Schedule with the SSCM and complete a review every six (6) months.

CHART 2890.1 - SPECIAL SITUATIONS IN CWFC		
IF	**THEN determine Medicaid eligibility for the child as:**	**AND determine financial eligibility**
an out-of-state CWFC child is placed in Georgia	ineligible for Georgia Medicaid under any COA. **NOTE:** The child is considered a legal resident of the state that retains custody. **NOTE:** The SSCM will assist the other state in locating Georgia providers who will accept the other state's Medicaid coverage.	N/A
a Georgia CWFC child is placed out-of-state	eligible in Georgia. **NOTE:** The SSCM in other state will assist the foster parents in locating providers who will accept Georgia Medicaid coverage.	child only
a CWFC child is returned to his/her parents for a trial placement	ineligible for CWFC Medicaid. Provide a timely notice. **NOTE:** Parents may apply for Medicaid for the child.	parents and child if parents apply for Medicaid
a CWFC child runs away	ineligible for CWFC Medicaid. Provide a timely notice. **NOTE:** the SSCM may reapply when the child returns.	child only
a CWFC child has a child living with him/her in placement	(the CWFC child's child) potentially eligible for: • LIM • Newborn (NB) • RSM • CWFC • MN	LIM: Child as AU of one, excluding CWFC parent and per diem NB: N/A RSM, CWFC and MN: BG including parent and child, including per diem of CWFC parent
a CWFC child has a child in foster care living in a separate placement	(the CWFC child's child) may be eligible for: • IV-E • RSM, • CWFC • MN	IV-E: Establish eligibility using BG from which child was removed. RSM, CWFC,MN: Child only

2895 - STATE ADOPTION ASSISTANCE MEDICAID

POLICY STATEMENT	State Adoption Assistance (SAA) Medicaid provides Medicaid coverage for a special needs child who is receiving State Adoption Assistance and who is ineligible for IV-E Adoption Assistance, but who is eligible for Medicaid under another Class of Assistance (COA).
BASIC CONSIDERATIONS	The month the SAA agreement is signed is considered the month of application for Medicaid if the child is not already Medicaid eligible. Eligibility is established for the month of application and ongoing, as well as any of the three months prior to the signing of the agreement. The child must be age 17 or under at the time SAA Medicaid is established. Eligibility continues through the month in which the child reaches 21 years of age, as long as the State AA agreement continues. **EXCEPTION:** If the child and the adoptive family move out of state, Georgia Medicaid is terminated.
PROCEDURES	Follow the steps below to determine initial Medicaid eligibility.
Step 1	Obtain and document the following information by the verbal statement of the Social Services Case Manager (SSCM). • A legally executed adoption assistance agreement (other than a IV-E agreement) is in place between the state and the adoptive parents and the date it was signed. • The child has pre-existing special medical and/or rehabilitative needs (pre-existing to the signing of the adoption assistance agreement). • The placement of the child in the adoptive home would not be possible without the Medicaid coverage. • The child's date of birth. • The Social Security number (SSN) of the child or statement of intent to apply for a SSN.

PROCEDURES (contd.)

Step 2 Establish if the child was receiving Medicaid under any Medicaid COA in the month of the signing of the SAA agreement.

If the child was receiving Medicaid, skip to Step 4.

If the child was not receiving Medicaid, proceed to Step 3.

Step 3 Determine the child's eligibility under any Family Medicaid COA for the month of the signing of the SAA agreement.

NOTE: Budget the child as an AU of one. Do not consider the adoptive parent's income or resources.

If eligible, proceed to Step 4.

If ineligible for the month the SAA agreement was signed, determine eligibility in any one of the three months prior to the signing of the agreement and continue eligibility ongoing.

NOTE: Budget according to the actual circumstances in the prior month.

Step 4 Notify the SSCM of the child's Medicaid eligibility.

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2900 - REFERRAL OVERVIEW

POLICY STATEMENT	In addition to the Services provided through the Medicaid Program, assistance is available through other public and private agencies.
BASIC CONSIDERATIONS	This section outlines the services provided by various agencies. The list is not all inclusive. Clients MUST be asked if they are interested in Voter Registration and Health Check referrals. All Medicaid recipients under age 21 are eligible to participate in Health Check.

2901 – DIVISION OF AGING (DHR)

POLICY STATEMENT	The Division of Aging administers a statewide system of services for older Georgians. These programs seek to secure maximum independence and dignity for seniors, especially for the vulnerable elderly.
BASIC CONSIDERATIONS	Services are offered through Area Agencies on Aging (AAA) each coordinating service delivery in a designated geographic area of the state. The following are services offered: • **Access Services** include outreach, which locates and identifies hard to reach older persons and assists them in gaining access to needed services, information and assistance, case management and transportation. • **In-Home Services,** such as homemaker/chore and personal care services, are provided to older citizens. Home delivered meals are distributed as part of the statewide nutrition program. Other in-home services include respite care, friendly visiting, telephone reassurance and home management. • **Community Services** include congregate nutrition services, which provide meals, nutrition education and counseling and other supportive services to older persons in centers throughout the state. The services may also include adult day care, legal assistance, and health promotion/disease prevention programs • **Long-Term Care Ombudsmen** investigate and mediate complaints regarding the quality of care and protection of the rights of long-term care residents. • **Employment** opportunities for economically disadvantage persons 55 and over are available through the Senior Community Service Employment Program. These opportunities include training, part-time community service employment and placement in unsubsidized employment.

BASIC CONSIDERATIONS (cont.)

- **The Community Care Services Program** provides the state's frail elderly and other disabled individuals with in-home health care, health related support services and places to live as alternatives to institutional care. This program serves functionally impaired Medicaid recipients throughout the state.

- **The Alzheimer's Disease and Related Disorders Program** provides support to people with dementia disorders and their caregivers. Projects serve clients with in-home respite care, day care center services and referrals.

- **The National Family Caregiver Support Program** provides support services to functionally impaired elders and their caregivers such as in-home respite care and day care, information and training, and assistance with access to services. This program also may assist seniors who are caring for grandchildren.

The Area Agency on Aging (AAA) coordinates a variety of services and information for the elderly and their caregivers including CCSP. The AAA serves as entry point for all programs and services, determining both client eligibility and the type of services needed.

Listed below are Georgia's 12 AAA Service Areas:

ATLANTA REGIONAL COMMISSION
CCSP Information – (404) 463-3244 (Atlanta)
Area Agency on Aging – (404) 463-3100 (Atlanta)
Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Rockdale, and Henry.

CENTRAL SAVANNAH RIVER
CCSP Information -- (706) 210-2018
Area Agency on Aging (706) 210-2018 (Augusta)
Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington and Wilkes.

COASTAL
CCSP Information - 800-580-6860 ext. 230 (Brunswick)
Area Agency on Aging – (912) 264-7363 (Brunswick)
Bryan, Bullock, Camden, Chatham, Effingham, Glynn, Liberty, Long and McIntosh.

GEORGIA MOUNTAINS
CCSP Information – 800-845-LINK or (770) 538-2650
Area Agency on Aging – (770) 538-2650 (Gainesville)
Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White.

HEART OF GEORGIA ALTAMAHA
CCSP Information – 888-367-9913 or
(912) 367-3648
Area Agency on Aging – (912) 367-3648 (Baxley)
Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler and Wilcox.

MIDDLE GEORGIA
CCSP Information – (478) 751-6466
Area Agency of Aging – (478) 751-6160 (Macon)
Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs and Wilkinson.

NORTHEAST GEORGIA
CCSP Information – 800-474-7540 or (706) 583-2546
Area Agency on Aging – (706) 369-5650 (Athens)
Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe and Walton.

NORTHWEST GEORGIA (formerly Coosa Valley/North Georgia
CCSP Information – 800-759-2963 or (706) 802-5506
Area Agency on Aging – (706) 295-6485
Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker and Whitfield.

SOUTH/SOUTHEAST GEORGIA
CCSP Information – (912) 287-5888 or 888-732-4464
Area Agency on Aging – (912) 285-6097 (Waycross)
Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner and Ware.

SOUTHERN CRESCENT – (formerly Chat-Flint/ McIntosh Trail)
CCSP Information – (706) 675-6721 or (770) 854-6026
Area Agency on Aging – (706) 675-6721 (Franklin)
(770) 854-6026 (Atlanta)
Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup and Upson.

SOUTHWEST GEORGIA
CCSP Information – (229) 432-1124 (Albany)
Area Agency on Aging – (229) 432-1124 (Albany)
Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas and Worth.

WEST CENTRAL (formerly Lower Chat/M. Flint)
CCSP Information – (706) 649-7494 or 800-615-4379
Area Agency on Aging – (706) 649-7468 (Columbus)
Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor and Webster.

2905 - CANCER STATE AID PROGRAM

POLICY STATEMENT	The Cancer State Aid Program funds diagnosis and treatment for medically needy cancer patients.
BASIC CONSIDERATIONS	Patients eligible for this service must meet the following criteria: • must be a U.S. citizen or an alien lawfully admitted to be a permanent resident; • must be a resident of Georgia; • must meet financial guidelines, at or below 200 percent of poverty, but not eligible for full coverage Medicaid. Due to funding restrictions, a limited number of applicants are accepted. Priority is given to those patients applying for recertification. New patients are prioritized and accepted based on cancer site, stage and expected treatment effectiveness as described in the latest scientific literature, cancer survival statistics, and funding availability. Services provided include: • Inpatient and outpatient cancer treatment at participating hospitals. • Outpatient chemotherapy and radiation therapy at approved free standing chemotherapy and radiation centers located in areas of the state that do not have Cancer State Aid participating hospitals or the participating hospital does not provide chemotherapy or radiation therapy. • Outpatient chemotherapy and other cancer related drugs provided by private pharmacies. Prior approval is required from the Cancer State Aid Program. • Other outpatient services such as home health care, nutrition supplements, oxygen, and equipment rental may be considered with prior approval by the Cancer State Aid Program.

PROCEDURES

Applications and information regarding the program can be obtained from:

- Local county health Departments
- Social Services Departments of participating hospitals
- Local County Departments of Family and Children Services (DFCS)
- Cancer State Aid Programs

Applications and the brochure "Team Work in Action, Cancer State Aid Program" may be obtained by calling the Cancer State Aid Program at 404-657-6600. It is recommended that the local DFCS office maintain a supply of the application and brochure.

Prior approval forms for Medication and Special Vendors may also be obtained from the Cancer State Aid Program.

Completed applications should be submitted to the Cancer State Aid Program for eligibility determination and assignment to the participating cancer facility closest to the applicant. This process will take approximately 20 working days from receipt of all required information. Applications will be considered based on the date they are received and the availability of funding.

Applications should be mailed to:

Cancer State Aid Program
Georgia Department of Human Resources
Division of Public Health
2 Peachtree Street
Suite 16-282
Atlanta, GA 30303

The Cancer State Aid Program web site is www.dhr.state.ga.us.

2910 – CHILD SUPPORT ENFORCEMENT

POLICY STATEMENT	In Georgia, the Office of Child Support Enforcement (CSE) provides the following services: • locate the non-custodial parent(s) • establish paternity • collect and distribute child support payments • establish and enforce medical support agreements • establish and enforce child support orders
CONTROLLING LEGISLATION	The CSE program was established under Title IV-D of the Social Security Act and is further developed in the Title 45 Code of Federal Regulations.
HISTORY	In 1975, the Social Security Act was amended to include Title IV-D, which requires states to establish a program to enforce the obligation of non-custodial parents to support their children. The federal Family Support Act of 1988 places the responsibility of paying child support on parents. Georgia enacted legislation in 1989 (HB 139) which made it one of the first states in the nation to meet the standards of the Family Support Act by setting guidelines for child support awards and requiring an income deduction for child support cases handled by CSE.
PROCEDURES	Clients may call the following numbers if their child support check is late, missing or is for the wrong amount: 404-657-2780 (in the metro Atlanta area) or 800-227-7993

2920 - DOMESTIC VIOLENCE

POLICY STATEMENT	Free, confidential services are available from domestic violence shelters and programs supported by the Department of Human Resources. DFCS will not share the information with anyone outside the agency without the applicant/recipient's knowledge.
BASIC CONSIDERATIONS	Domestic violence occurs on all social and economic levels, regardless of employment or education, race or ethnic background, religion, marital status, physical ability, age or sexual orientation.
24-Hour Help Line	Customers may call 1-800-33HAVEN to speak to someone at a local domestic violence shelter. Customers may call from anywhere in the state to find a safe place to stay for themselves and their children, and to get other resources. Workers may call the DFCS Family Violence Unit at 404-463-7079 for more information or assistance. The brochure "What Every Woman Needs to Know" is available at Central Supply and may be used to assist the worker and/or customer in determining if a Domestic Violence referral is appropriate. When in doubt, offer the help line number to the customer.

2925 – THE FOOD STAMP PROGRAM (DHR/DFCS)

POLICY STATEMENT	The purpose of the Food Stamp Program is to promote the well being of the state's population by raising the level of nutrition among low-income assistance units. The Food Stamp Program provides monthly benefits through Electronic Benefit Transfer (EBT) to low income families to help pay for the cost of food.
CONTROLLING LEGISLATION	The Food Stamp Program is authorized by the Food Stamp Act of 1977. The eligibility provisions of the Act are further developed in Title 7, Code of Federal Regulations, parts 210 through 299. The Food Stamp Program is administered by the Food and Nutrition Service under the United States Department of Agriculture.
HISTORY	The legal basis for the Food Stamp Program is the Food Stamp Act of 1977, the Omnibus Reconciliation Act of 1981, and the Food Security Act of 1964. Benefits are funded 100 percent by the federal government, and administrative costs are shared by the state and federal governments on a 50-50 basis.
BASIC CONSIDERATIONS	Applications for Food Stamps are accepted at the local DFCS office and Social Security Administration. Applications taken at the Social Security Administration are forwarded to DFCS for processing.

2927 - GEORGIA PARTNERSHIP FOR CARING FOUNDATION

POLICY STATEMENT	The Georgia Partnership for Caring Foundation (GPCF) is a network of health care providers who donate their time, services and procedures to serve Georgia's low income uninsured residents.
HISTORY	The Georgia Partnership for Caring Foundation is a non-profit organization formed in 1994 by former Lt. Governor Pierre Howard, State Senator Charles Walker and various public and private health care associations and human services agencies. GPCF was created as a response to the problem for providing access to health care services for Georgia's low income uninsured residents.
BASIC CONSIDERATIONS	To be eligible for GPCF services, the client may not have private insured available or qualify for any public health coverage programs (including Medicare or Medicaid). Income must fall below 100% of the Federal Poverty Level. Clients who have Medicare, Medicaid, or other insurance, but who do not have prescription coverage should be referred to CPCF for help with their pharmaceutical needs (i.e. QMB recipients). Clients whose only coverage is Medically Needy in suspense status should also be referred. The program includes limited voluntary services of physicians, nurse practitioners, hospitals, pharmacists, pharmaceutical manufacturers and many other health provider agencies. GPCF can: • refer the client to a volunteer provider. There is no charge for the first routine office visit. • refer the client to a specialist. There is no charge for the first routine office visit. • provide certain prescription medications free of charge. These medications must be prescribed through a physician participating in the CPCF program. • provide certain hospital, home health, or hospice benefits if referred by a physician participating in the CPCF program. CPCF cannot pay for any past medical bills, emergency room services, lab tests, x-rays or visits to non-participating providers and/or families.

PROCEDURES

To apply for GPCF, the client may call 1-800-982-4723, Monday through Friday, 9:00 AM through 4:00 PM.

Clients may also apply for CPCF through the RSM Project.

The Foundation will review the application, which may take four to six weeks.

Once approved, CPCF recipients will receive an identification card. This card must be presented to providers at the time services are received.

2930 - HEALTH CHECK SERVICES

POLICY STATEMENT

Health Check is a comprehensive health program which provides basic screening and diagnostic services, as well as, follow-up treatment if abnormalities are detected.

All Medicaid recipients under age 21 and all Peach Care for Kids recipients under the age of 19 are eligible to participate in this program.

BASIC CONSIDERATIONS

There are twenty (20) screening sequences. The number of screenings will depend on the child's age at the time of request for Health Check services.

Health Check providers are Pediatricians, Family Practice Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Schools, Hospitals and Public Health Departments that are enrolled in the Health Check program. Health Check services include, but are not limited to the following:

- Health Check examination, that includes:
  - an unclothed physical examination
  - laboratory tests
  - immunizations
  - checks for vision and hearing
  - anticipatory guidance
  - developmental/behavioral assessment
  - dental referrals
- notifies A/Rs when screenings are due
- assistance with needed transportation
- assistance with scheduling appointments

  NOTE: A/R selects provider of his/her choice.

- assistance in locating the nearest Health Check provider

  NOTE: If the A/R declines the offer initially, a request for Health Check and supportive services can be made at any time after Medicaid or Peach Care for Kids is approved.

- provides information to the blind, deaf, illiterate or non-English speaking through suitable communication resources.

PROCEDURES

Inform the A/R about the program verbally and in writing at the time of application or reapplication for Family Medicaid.

Provide a copy of the Current Health Check brochure to the A/R during the personal contact or mail it to the A/R. If the brochures are unavailable, provide the following phone number for the nearest clinic, doctor or dentist participating in Health Check:

1-800-934-9206

Explain the benefits of preventive health care services and the services offered under the program including the following:

A. Benefits

- the prevention of some diseases/disability before occurrence
- early detection can prevent some disease/disabilities from progressing
- some diseases/disabilities can be corrected if diagnosed and treated early
- early medical and dental intervention can help a child achieve his/her full potential.

B. Services

- Explain that upon a determination of eligibility for Medicaid all individuals under age 21 can receive Health Check Services.

2935 – NON-EMERGENCY TRANSPORTAION BROKER SYSTEM

POLICY STATEMENT	The Medicaid Non-Emergency Transportation (NET) program provides transportation through a NET Broker System. Non-emergency transportation is provided only in the absence of other transportation.
BASIC CONSIDERATIONS	Five NET regions have been established in the state – North, Atlanta, Central, East and Southwest. DMA has contracted with a Broker in each of the five NET regions to administer and provide non-emergency transportation for eligible Medicaid recipients. The Brokers are reimbursed a monthly capitation rate for each Medicaid recipient residing in their region.
PROCEDURES	Medicaid recipients who need access to medical care or services covered by Medicaid and have no other means of transportation must contact the Broker servicing their county to arrange for appropriate transportation. Each Broker is required to maintain toll free telephone access for transportation scheduling services Monday through Friday from 7:00 a.m. to 6:00 p.m. DMA has contracted with two companies to provide Broker services. **Southeastrans, Inc.**, serves the Atlanta Region; and **LogistiCare** the North, Central, East and Southwest Regions. County groupings and related Broker scheduling telephone numbers for each region are as follows:

North-LogistiCare **Toll free** 800-807-5030	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Clarke, Cobb, Dade, Dawson, Douglas, Elbert, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Greene, Gwinnett, Habersham, Hall, Haralson, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Newton, Oglethorpe, Oconee,, Paulding, Pickens, Polk, Rabun, Rockdale, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta-Southeastrans, Inc. (770) 693-8401	Fulton and DeKalb
Central-LogistiCare **Toll free** 888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Crawford, Dodge, Fayette, Hancock, Heard, Henry, Houston, Jasper, Johnson, Jones, Lamar, Laurens, Meriwether, Monroe, Montgomery, Peach, Pike, Pulaski, Putnam, Spalding, Telfair, Treutlen, Troup, Twiggs, Upson, Washington, Wheeler, Wilcox and Wilkinson
East-LogistiCare **Toll free** 888-224-7988	Appling, Atkinson, Bacon, Brantley, Bryan, Burke, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Columbia, Effingham, Emanuel, Evans, Glascock, Glynn, Jeff Davis, Jefferson, Jenkins, Liberty, Lincoln, Long, McDuffie, McIntosh, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Ware, Warren, Wayne and Wilkes
Southwest-LogistiCare **Toll free** 888-224-7985	Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Colquitt, Cook, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Irwin, Lanier, Lee, Lowndes, Macon, Miller, Mitchell, Muscogee, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Webster and Worth

2937 - OMBUDSMAN

POLICY STATEMENT	Anyone with a question or concern about long-term care may contact the Georgia Long-Term Care Ombudsman Program.
BACKGROUND	The Long-Term Care Ombudsman Program is governed by the federal Older Americans Act and by Georgia law. The Division of Aging Services of the Department of Human Resources administers the statewide Long-Term Care Ombudsman Program through 13 community programs located throughout the state. These programs are affiliated with Area Agencies on Aging and funded with federal, state and local dollars.
BASIC CONSIDERATIONS	The Long-Term Care Ombudsman seeks to improve the quality of life of the residents of long-term care facilities. These facilities include nursing homes and personal care homes, often called assisted living facilities or residential care facilities. There is no charge for services provided by the ombudsman program. Functions of the Long-Term Care Ombudsman include the following: • Investigates and works to resolve problems or complaints affecting long-term care residents. • Identifies problem areas in long-term care and related services. • Provides information about long-term care and related services. • Promotes resident, family and community involvement in long-term care. • Educates the community about the needs of long-term care residents. • Coordinates efforts with other agencies concerned with long-term care. • Visits long-term care facilities routinely to talk to residents and monitor conditions. • Educates facility staff about resident rights and other issues.

BASIC CONSIDERATIONS (cont.)

The Ombudsman handles the following issues:

- Rights of long-term care residents
- Care provided in long-term care facilities
- Transfers and discharges from long-term care facilities, including assistance with appeals.

The brochure "Ombudsman Long-Term Care Resident's Advocate" is available from the State Ombudsman Program. It is recommended that these brochures be available for customers of the ABD program.

Address

State Ombudsman Program
Division of Aging Services
2 Peachtree Street, NW
Suite 9-100
Atlanta, GA 30303-3176

888-454-LTCO (5826)

2940 – PRESCRIPTION PRIOR APPROVAL (DMA)

POLICY STATEMENT	A/Rs whose physicians have ordered more than the approved five prescriptions in a month may request approval from DMA for Medicaid to cover these extra prescriptions. DMA may approve or deny the request for the extra prescriptions.
BASIC CONSIDERATIONS	Although the process to get additional prescriptions covered by Medicaid is not an activity completed by eligibility workers, it is a question that is frequently asked of the Medicaid staff. Information on this process is contained in this section so that staff can inform A/Rs and providers on how to get additional prescriptions approved and also for emergency billing procedures for prescriptions.
PROCEDURES	To request prior approval, the A/Rs physician or pharmacist is to follow the instructions provided in the DMA Provider Policy Manual. An outline of the instructions follows.
Prior Approval	The physician/pharmacist requests DMA prior approval by calling Express Scripts at 877-650-9340. This is a **provider only** number. Approval is granted over the telephone. If the request is denied, the appeal process is explained at the time of the denial. The provider is responsible for the appeal process.
Emergency Billing	Emergency Billing or prescribing is for emergency situations only. The physician or pharmacist is to follow the instructions in the DMA Provider Policy Manual. Providers having questions about emergency billing or prescribing should call DMA staff pharmacists at (404) 656-4044. A/Rs having questions about emergency procedures are to call 800-282-4536, or (404) 656-3200.

2942 – DIVISION OF PUBLIC HEALTH (DHR)

POLICY STATEMENT	The Division of Public Health promotes the well being of Georgians of all ages by providing health care, health education, counseling, referral and environmental monitoring.
BASIC CONSIDERATIONS	
Family Health	Women and children receive nutritious foods and nutrition information through the Women, Infants, and Children program (WIC). The perinatal case management program works with low-income pregnant women to help them have healthy pregnancies and healthy babies. Family planning services are provided to men and women. Chronically ill and physically disabled children are helped through the Children's Medical Services Program. Infants, children and adults are immunized against infectious diseases. School children are screened for vision, dental health, hearing and scoliosis and visit the health department for assessment and care.
Community Health	County health departments treat persons for gonorrhea and syphilis. At public health clinics, people are screened for hypertension and women are screened for cervical and breast cancer. Migrant workers are treated or referred for treatment by the migrant health program in the Columbus, Macon, Metter and Dublin districts.
Emergency Health and Environmental Health	The division's regulatory functions include licensing and monitoring ambulance services and certifying Emergency Medical Technicians. Other regulatory activities include evaluations of personal care homes and inspections of restaurants, tourist accommodations, and other facilities.
AIDS Project	Health education, testing for HIV infection, counseling and referral services are provided throughout Georgia.

BASIC CONSIDERATIONS (cont.)

Epidemiology The Office of Epidemiology collects data on reportable diseases and investigates disease outbreaks.

Laboratory The state laboratory in Atlanta and three regional laboratories aid in the control of infections and chronic disease by processing patient specimens and performing exams on these specimens.

Vital Records The unit registers records of births, deaths, spontaneous abortions, induced abortions, marriages and divorces.

Primary Health Care Fifteen federally-funded and five state-funded centers provide primary health care. Clinics in Atlanta and Savannah, which are state-supported, provide basic health care to homeless persons.

2945 – THE REFUGEE RESETTLE MENT PROGRAM (DHR/DFCS)

POLICY STATEMENT	The Refugee Resettlement Program (RRP) provides cash and/or medical assistance to refugee adults and families in the United States who meet eligibility criteria. RRP is approved without regard to national origin. It is the purpose of RRP to provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible. Cash and medical assistance benefits are available to refugees, asylees, Cuban/Haitian entrants, Vietnamese Amerasians, and victims of human trafficking who do not qualify for TANF and/or Medicaid. These benefits are available during their first eight months in the country, or after having been granted status in one of the above.
CONTROLLING LEGISLATION	The legal basis for RRP is the Immigration and Naturalization Act (INA) and the Refugee Act of 1980, as amended.
HISTORY	The Refugee Resettlement Program (RRP) was authorized by the Refugee Act of 1980 (P.L. 96-212) to provide cash assistance, medical assistance, and social services to refugees. The Fascell-Stone Amendment to the Refugee Education Assistance Act of 1980 (P.L. 96-422) extended to Cuban and Haitian entrants the same benefits and services available to refugees. The law was amended by the Refugee Assistance Amendments of 1982 (PL 97-363). In the Continuing Resolution of 1983 (PL 97-377), the Cuban/Haitian Entrant Program was combined with the RRP so that both refugees and entrants were served by the same program. The law was further amended by the Refugee Assistance Extension Act of 1986 (P.L. 99-605). In 1988 the Amerasian Homecoming Act (P.L. 100-202) admitted Amerasians and their families as immigrants, making them eligible for refugee benefits. In 2000 the Trafficking Victims Protection Act (P.L. 106-386) made victims of severe forms of trafficking eligible for refugee benefits and services.
BASIC CONSIDERATIONS	Applications for the Refugee Resettlement Program for refugees in the metropolitan Atlanta area are accepted at the multi-county Refugee Resettlement Unit which is located at Fulton County DFCS, 75 Marietta Street, N.W., 2nd Floor, Atlanta, Georgia 30303-2883. Refugees in other areas of the state should apply at their local DFCS office.

2947 – OFFICE OF REGULATORY SERVICES (DHR)

POLICY STATEMENT

The Office of Regulatory Services is responsible for licensing, registering, and certifying a variety of health and childcare programs. This is accomplished through periodic inspection and the investigation of complaints. It works to ensure that facilities and programs operate at acceptable levels, as mandated either by the state statutes and rules and regulations adopted by the Board of Human Resources. ORS also certifies various health care facilities to receive Medicaid and Medicare funds through contracts with the Center for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

BASIC CONSIDERATIONS

Child Care Programs

ORS inspects and licenses day care centers, group day care homes, residential care facilities, and private adoption agencies. The office also registers family day care homes, which are private residences that provide care for three to six children, and inspects a sample of these homes yearly.

Health Care Facilities

ORS regulates both long-term and primary care facilities. Long-term care facilities include skilled nursing homes and intermediate care nursing homes and personal care homes. Primary care facilities and programs include general and specialized hospitals, clinical laboratories, home health agencies, rehabilitation centers, end-stage renal centers, drug abuse treatment facilities, hospices, ambulatory surgical treatment centers, x-ray machines, and several other types of facilities such as rural health clinics. Many of the regulated health care facilities are certified by ORS for reimbursement under the Medicare and Medicaid programs.

More detailed information about specific programs, including a like to applicable rules and regulations can be found at www2.dhr.state.ga.us/departments/dhr/org. A listing of all regulated providers is also available at that site.

BASIC CONSIDERATIONS (cont.)

Complaints about regulated programs can be submitted by telephone or in writing. Complaints about regulated programs can be submitted by telephone or in writing. Complaints concerning childcare programs can be filed by calling 404-657-5563. Complaints regarding health care facilities can be filed by calling 404-657-5726 or 1-800-878-6442. Written complaints for all programs can be sent to:

Office of Regulatory Services
Complaint Unit
2 Peachtree St, N.W.
Room 32-415
Atlanta, Georgia 30303-3142

2950 – DIVISION OF REHABILITATION SERVICES (DOL)

POLICY STATEMENT

The Division of Rehabilitation Services offers a full range of services to meet the needs of Georgians with physical, mental and emotional disabilities. Employees include physicians, nurses, counselors, evaluators, adjudicators, instructors and health service technicians who deliver services statewide.

BASIC CONSIDERATIONS

Competitive Employment

Georgians with disabilities are returned to employment through the services offered by rehabilitation counselors located in 53 offices statewide. The services, which are free to eligible persons, include vocational, psychological and medical evaluations, guidance, vocational counseling and job placement.

State-operated rehabilitation centers in Augusta, Cave Springs, Atlanta, Rome and Milledgeville provide various combinations of services including vocational evaluations, adjustment services, psychological testing, and medical consultations, as well as sheltered employment at some locations.

Sheltered Employment

The Division operates and contracts with community-based facilities for sheltered employment programs for persons who are severely disabled and currently unable to work in the competitive labor market.

Georgia Industries for the Blind provide training and employment in manufacturing and packaging for persons who are blind or have other visual impairments. Plants located in Bainbridge, Griffin, and Atlanta employ disabled workers. In addition, persons who are blind work in the Business Enterprise Program, operating vending facilities throughout the state.

Independent Living

Field-based independent living programs, currently in Atlanta, Columbus, Albany, Savannah, Gainesville and Macon, teach persons with disabilities the skills they need to become more self-sufficient in the community. Services include technical assistance, information and referral.

BASIC CONSIDERATIONS (cont.)

Disability Adjudication

Georgians with physical disabilities file claims for Social Security disability and receive eligibility decisions from the department's Disability Adjudication Section.

Roosevelt Warm Springs Institute for Rehabilitation

The institute provides extensive residential and outpatient services for persons with physical and mental disabilities. Services include medical and vocational rehabilitation, independent living skills training, education and research.

Specialized Services

In 1988, the division opened the Georgia Sensory Rehabilitation Center in College Park offering specialized rehabilitation, job training and job placement for persons with sensory disabilities. Through a cooperative agreement with the Georgia Head Injury Foundation, Inc., the Traumatic Brain Injury Center serves Georgians from across the state. The Georgia Interpreting Services Network provides sign language interpreters.

2960 – TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

POLICY STATEMENT

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 eliminated the open-ended entitlement of Aid to Families with Dependent Children (AFDC). The PRWORA created a block grant for states to provide time-limited cash assistance for needy families, with work requirements for most recipients. The law also made far-reaching changes to childcare, the Child Support Enforcement Program and benefits for legal immigrants.

BASIC CONSIDERATIONS

The PRWORA eliminated the AFDC program, JOBS, and Emergency Assistance (EA), and created the Temporary Assistance to Needy Families (TANF) Block Grant. The purposes of TANF are to:

- provide assistance to needy families so that children can be cared for in their homes or in the homes of relatives
- end the dependency of needy parents on government benefits by promoting job preparation, work, and marriage
- prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies
- encourage the formation and maintenance of two-parent families.

In operating the TANF program, Georgia's primary goal is to provide necessary assistance on a temporary basis to needy families with children, and to provide parents with job preparation, work opportunities, support services, and enforcement of child support obligations to children living in these families. In so doing, Georgia will enable needy families to become self-sufficient and leave the TANF program as soon as possible.

BASIC CONSIDERATIONS (cont.)	Promoting the well being of the children of Georgia is the mission of the Department of Human Resources, Division of Family and Children Services. In order to fulfill its mission, the Department assists families in their efforts to acquire the necessary means to achieve economic self-sufficiency. Assistance is provided in the following manner: • work activities that include job search, job training, and assistance with job placement, • support services such as child care, transportation, and other necessary expenditures that assist families in obtaining employment and remaining employed, thus eliminating the need for cash assistance, • cash assistance that is provided either by check or electronic benefit transfer, • support services intended to support and maintain two-parent families, and • support services intended to prevent teen and out-of-wedlock pregnancies.
PROCEDURES	Applications for TANF are accepted at the local DFCS office.

2980 – VOTER REGISTRATION

POLICY STATEMENT	Effective January 1, 1995, county DFCS offices are designated as agencies for voter registration.
BASIC CONSIDERATIONS	Staff in each county department office will perform the following voter registration services: • develop office procedures and identify the personnel required to assure that the minimum requirements are met, • the county may designate administrative, supervisory, casework, support staff, work experience participants or volunteers to provide voter registration services, • offer voter registration services to an A/R at each face-to-face interview for an initial application, review or report of change of address, • distribute the mail voter registration application packets, • assist the A/R with completing the voter registration application, if requested, • explain the applicant voter's rights and responsibilities, • accept completed voter registration applications, • mail completed voter registration application forms to the Office of the Secretary of State daily, • maintain copies of the completed voter registration declaration form in a central file (Form DS-95) for 24 months, • develop a working relationship with the local Election Board, • cooperate with federal and state audits,

BASIC CONSIDERATIONS (cont.)	• maintain a sufficient supply of voter registration application packets, • provide on-going voter registration services training to county staff, • offer services during regular office hours, • develop a plan of implementation and operation for each office site where applications, reviews and changes are accepted for the Food Stamp Program, • designate a lead or contact person for each office site.
SPECIAL CONSIDERATIONS	**DO NOT:** • seek to influence an applicant's political preference or party registration; • display any such political preference or party allegiance; • make any statement to an applicant or take any action to discourage the applicant from registering to vote; • make any statement to an applicant or take any action which leaves the applicant with the impression that a decision to register or not to register has any bearing on the availability of program services or benefits; • attempt to determine the applicant's eligibility to register (the Board of Elections will make this determination); • argue if a person wants to fill out a voter registration application.

PROCEDURES

Plan of Implementation

Each county must complete a Form MVI (12/94), Plan for Implementation and Operation of the National Voter Registration Act (NVRA) for each office site, initially and whenever significant changes in the plan occur. Submit the completed form to the State Office, ESSS:

Division of Family and Children Services
ESSS - Economic Support Services Section
2 Peachtree Street, NW, Suite 21-212
Atlanta, Georgia 30303-3180

A completed copy is maintained in the county for audit purposes.

Voter Registration Forms

Voter registration applicant/change of address forms and other voter registration supplies are ordered from DHR Central Supply.

The cost of all forms and postage connected with voter registration is paid by the Office of the Secretary of State, Election Board.

NOTE: Copies of the voter registration forms are included in this section.

Office Procedures

Step 1 Integrate the voter registration services into the regular office process so that each A/R who is seen in person during office/home/field visits for each initial application, review or report of change of address is offered the opportunity to apply to register to vote. **NOTE:** It is noted that duplication of services will occur.

Step 2 Provide the declaration statement (Form DS-95) to the A/R to document either the acceptance or declination of the service. Retain this page and maintain for a 24-month period and file chronologically by year/month.

PROCEDURES

Office Procedures (cont.)

Step 3 Offer to assist the A/R with completing the application/change of address form. Complete the form, if requested.

Step 4 Allow the A/R to complete the application/change of address form and request that the A/R return it to DFCS for submission to the Office of the Secretary of State.
OR
The A/R may retain the application/change of address form for submission at a later time. A self-addressed envelope is enclosed in the packet for mailing of the form by the A/R directly to the Office of the Secretary of State.

Step 5 Mail the completed application/change of address forms to the Office of the Secretary of State daily.

Step 6 Complete Form ATF-96, Agency Daily Recap Reporting Form, in duplicate, and mail a copy to the Office of the Secretary of State. Retain the duplicate copy in the county.

NOTE: A preaddressed postage paid envelope is provided for the daily mailings.

Direct inquiries regarding the status of the voter registration application, complaints or other related issues to the:

Office of the Secretary of State
1104 West Tower
Two Martin Luther King, Jr. Drive, S.E.
Atlanta Georgia 30334

Or

by calling (404) 656-2871

Or

Refer to the local voter registration office.

2985 - WOMEN, INFANTS AND CHILDREN (WIC) SERVICES

POLICY STATEMENT

Applicants/recipients for Medicaid are referred to the County Public Health Department or other WIC agency for possible participation in the WIC program if they fall into one of the following categories:

- pregnant women
- women who are breast-feeding through the first 12 months after the birth of the child
- children under age 5
- postpartum women (eligible for six months following the termination of pregnancy).

PROCEDURES

Follow the procedures below to refer A/Rs to WIC services.

Verbally inform the A/R of the WIC services available and the location of the Public Health Department.

Include this information in the explanation of services.

- WIC provides infant formula, baby cereal and fruit juice for children who are bottle-fed from birth to 1 year.
- WIC provides cheese, cereal, fruit juice and eggs for pregnant women, nursing women, and children 1 to 5 years of age.
- Document the case record to indicate that the A/R was notified and referred for WIC services.

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS				
Type Limit	**Individual Limit**	**Couple Limit**	**LA-D Individual With a Community Spouse**	**Effective Date**
SSI	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/QIS/ QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$89,280 + 2000 = $91,280.00	1-02

CHART A1.2 - ABD MEDICAID INCOME LIMITS				
Type Limit	**LA**	**Individual Limit**	**Couple Limit**	**Effective Date**
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$545	$817	1-02
	B	$363.34	$545	
	C	$545	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1635	$3270	1-02
QDWI	A	$3019	$4045	3-02 Note: Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	C	$3019	N/A	
	D	$3019	N/A	
QMB	A	$739	$995	4-02
SLMB	A	$886	$1194	4-02
QI-1	A	$997	$1344	3-02
QI-2	A	$1293	$1742	3-02

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION		
Averaging Nursing Home Private Pay Billing Rate	$3131	4-02

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD				
Income Limit	**PMV for an Individual**	**PMV for a Couple**	**Living Allowance**	**Effective Date**
AMN	$201.66	$292.33	$273	1-02
FBR	$201.66	$292.33	$273	1-02
QDWI	N/A	N/A	$670	3-02
QMB	N/A	N/A	$339	4-02
SLMB	N/A	N/A	$405	4-02
QI-1	N/A	N/A	$455	3-02
QI-2	N/A	N/A	$588	3-02

QI-2 Refund Amount is $3.91 effective 1-02.

Medicare Part B Premium rate is $54.00 effective 1-02.

Maximum earnings for substantial gainful activity (SGA) are $780.00 per month.

CHART A1.5 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT		
IF the LA-D Recipient is	**THEN use the following as the PNA in the Patient Liability/Cost Share Budget:**	
an individual in a nursing home	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents **NOTE:** The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in MRWP	the current Medicaid Cap	

CHART A1.6 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET		
Diversion Standard	**Amount**	**Effective Date**
Community Spouse Maintenance Need Standard	$2232	1-02
Dependent Family Member Need Standard	$1513	4-02

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS				
Type Limit	**Individual Limit**	**Couple Limit**	**LA-D Individual With a Community Spouse**	**Effective Date**
SSI	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/QIs/ QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$87,000 + 2000 = $89,000.00	1-01

CHART A1.2 - ABD MEDICAID INCOME LIMITS				
Type Limit	**LA**	**Individual Limit**	**Couple Limit**	**Effective Date**
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$530 / $531	$796/ $796	1-01/8-01
	B	$353.34/ $354	$530/ $530.67	
	C	$530/ $531	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1590/ $1593	$3180/ $3186	1-01/8-01
QDWI	A	$1392/$1432	$1876/$1935	3-00/3-01 Note: Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	C	$1432	N/A	
	D	$1432	N/A	
QMB	A	$696/$716	$938/$968	4-00/4-01
SLMB	A	$836/$859	$1126/$1161	4-00/4-01
QI-1	A	$940/$967	$1267/$1307	3-00/3-01
QI-2	A	$1218/$1253	$1642/$1694	3-00/3-01

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION		
Averaging Nursing Home Private Pay Billing Rate	$2930/$3042	4-96/4-01

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$196.66/$197	$285.33	$266/$266	1-01
FBR	$196.66/$197	$285.33	$266/$266	1-01
QDWI	N/A	N/A	$625.33/$651.67	3-00/3-01
QMB	N/A	N/A	$313/$329.34	4-00/4-01
SLMB	N/A	N/A	$375.33/$393.67	4-00/4-01
QI-1	N/A	N/A	$422.33/$443	3-00/3-01
QI-2	N/A	N/A	$547.33/$571.34	3-00/3-01

QI-2 Refund Amount is $3.09 effective 01-01.

Medicare Part B Premium rate is $50.00 effective 01-01.

CHART A1.5 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT		
IF the LA-D Recipient is	**THEN use the following as the PNA in the Patient Liability/Cost Share Budget:**	
an individual in a nursing home	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents **NOTE:** The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	

CHART A1.6 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET		
Diversion Standard	**Amount**	**Effective Date**
Community Spouse Maintenance Need Standard	$2175	1-01
Dependent Family Member Need Standard	$1472	1-01

APPENDIX A.2 FAMILY MEDICAID 2002

2002 INCOME LIMITS

	LIM	LIM	RSM PgW, NB, PCK	RSM CHILD 0-1 TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	GROSS INCOME CEILING (GIC)	STANDARD OF NEED (SON)	235% FEDERAL POVERTY LEVEL (FPL)	185 % FEDERAL POVERTY LEVEL (FPL)	133% FEDERAL POVERTY LEVEL (FPL)	100 % FEDERAL POVERTY LEVEL (FPL)	FAMILY MEDICAID MNIL
1	$ 435	235	1736	1366	982	739	208
2	.659	356	2339	1841	1324	995	317
3	584	424	2942	2316	1665	1252	375
4	925	500	3545	2791	2007	1509	442
5	1060	573	4148	3266	2348	1765	508
6	1149	621	4751	3741	2689	2022	550
7	1243	672	5355	4215	3031	2279	600
8	1319	713	5958	4690	3372	2535	633
9	1389	751	6562	5166	3714	2792	667
10	1487	804	7166	5642	4056	3049	708
11	1591	860	7770	6118	4398	3306	758
12	1635	884	8374	6594	4740	3563	808
(+) PER ADDITIONAL BG MEMBER	44	24	604	476	342	257	50

2002 RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT NUMBER OF INDIVIDUALS IN FM-MN BG											
1	2	3	4	5	6	7	8	9	10	11	12
$ 2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

(10/2001)

APPENDIX A.2 FAMILY MEDICAID 2001

2001 INCOME LIMITS

	LIM	LIM	RSM PgW, NB, PCK	RSM CHILD 0-1 TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	GROSS INCOME CEILING (GIC)	STANDARD OF NEED (SON)	235% FEDERAL POVERTY LEVEL (FPL)	185 % FEDERAL POVERTY LEVEL (FPL)	133% FEDERAL POVERTY LEVEL (FPL)	100 % FEDERAL POVERTY LEVEL (FPL)	FAMILY MEDICAID MNIL
1	$ 435	235	1683	1325	953	716	208
2	659	356	2275	1791	1288	968	317
3	584	424	2867	2257	1623	1220	375
4	925	500	3457	2722	1957	1471	442
5	1060	573	4050	3188	2292	1723	508
6	1149	621	4642	3654	2627	1975	550
7	1243	672	5232	4119	2961	2226	600
8	1319	713	5824	4585	3296	2478	633
9	1389	751	6416	5051	3631	2730	667
10	1487	804	7008	5517	3966	2982	708
11	1591	860	7600	5983	4301	3234	758
12	1635	884	8192	6449	4636	3486	808
(+) PER ADDITIONAL BG MEMBER	44	24	592	466	335	252	50

2001 RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT NUMBER OF INDIVIDUALS IN FM-MN BG											
1	2	3	4	5	6	7	8	9	10	11	12
$ 2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

(10/2001)